The Intersubjective Arena of the Psychotherapy for Psychosis: A Phenomenological Account of Therapists' Experiences

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STATEMENT OF AUTHORSHIP

This dissertation was written by Andreas Vassiliou and has ethical clearance from the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University. It is submitted in partial fulfilment of the requirements of the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University for the Degree of Doctor of Existential Counselling Psychology. I confirm that this is an original piece of work and has not previously been submitted and approved for the award of a degree by this or any other University within or outside the United Kingdom. This thesis is, therefore, the product of my personal investigations and any material and information that have been employed that is not my own have been appropriately identified by providing references which are appended.

ABSTRACT

New exciting literature that points to the significance of considering intersubjective processes in therapeutic work with people diagnosed with psychosis has been recently developed in the realms of phenomenological psychology and psychiatry. However, the research literature reveals an emphasis towards the exploration of clients' processes and an underestimated inclination towards the in-depth exploration of therapists' experiences that work from an intersubjective/interrelational perspective with this client group. Given this particular limitation, we therefore need a more detailed exploration of what this work is like, and how therapists make sense of this work considering this intersubjective turn. This project has therefore attempted to shed light on the intersubjective processes of psychotherapy for psychosis from the therapists' point of view while emphasising how the therapeutic praxis can be grounded upon firm existential-phenomenological principles. The study explored the subjective experiences of six counselling psychologists and/or therapists who identified themselves as working intersubjectively with psychosis. After careful consideration, Interpretative Phenomenological Analysis (IPA) was employed as the most suitable methodology in order to explore the interviews and to gain insight into participants' lived experiences of their relationships with clients. The analysis of data revealed four key themes: the primacy of sense-making, a relational approach to therapy, therapists' processes in the rupture of relatedness and the lived experience of being-with. Despite the congruence with the limited literature on therapists' lived experiences of their intersubjective work with psychosis, the results of this study also shed light on some neglected areas of consideration with regards to the therapeutic process, while encouraging the consideration of existential/phenomenological contributions towards both the understanding and clinical praxis of the psychotherapy for psychosis. This piece of work consists therefore of a significant contribution to the limited literature on phenomenological and intersubjective work with psychosis and is an essential addition to counselling psychology literature.

Keywords: Psychosis, Intersubjectivity, Counselling Psychology, Psychotherapy

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ABBREVIATIONS

BPS:	British Psychological Society
CoP:	Counselling Psychology
CoPt	Counselling Psychologist
E-P:	Existential-Phenomenological
APA:	American Psychiatric Association
IPA:	Interpretative Phenomenological Analysis
DSM:	The Diagnostic and Statistical Manual of Mental Disorders
ICD:	The International Classification of Diseases
NHS:	National Health Service
CBT:	Cognitive Behavioural Therapy

TRANSCRIPT NOTATIONS

(P):	Significant pause
(p):	Brief pause
[redacted]:	Real name (person, organization, setting, etc.) omitted to safeguard anonymity
[redacted]:	Information omitted to safeguard confidentiality

TERMINOLOGY

It should be noted that all terminology employed will be as thoroughly defined as possible and presented within the epistemological and ontological frameworks within which the study was conducted. I am aware that some readers may not feel comfortable with the employment of the term 'psychosis' and the phrases *individual(s) diagnosed with psychosis* or *person(s) with psychosis* will be employed in this research paper in an effort to avoid using terms like *psychotic* or *schizophrenic* which are considered to stigmatise individuals (e.g. Haghighat, 2008; Dinos et. al, 2004; Keusch, Wilentz, & Kleinman, 2006). Words or phrases within single quotation marks that are presented throughout the research will be employed to indicate constructed ideas, notions and concepts, or conditions that have been considered according to their context of interest (e.g. medical and psychiatric settings), with the intention of bringing taken for granted concepts into an open enquiry for the reader. Moreover, it should be noted that when I am referring to *discourse/s,* I refer to patterns or regularities routed in language or written form, therefore, the ways in which we think about particular phenomena (e.g. Bakhtin, 1981).

“Εάν μη έλπηται
ανέλπιστον ουκ εξευρήσει,
ανεξερεύνητον εόν και άπορον”

(Ηράκλειτος)

“*If you don't bear hope*
you will not discover the unforeseen
by rendering it unexplored and beyond reach”

(Heraclitus)

PREFACE

NOTE ON WRITING STYLE

This research project has been written with a view to submitting to a British Psychological Society Journal. It has therefore been written according to the British Psychological Society's style guidelines and has followed the American Psychological Association's referencing and citation style (American Psychological Association, 2010). In constructivist research methodologies where a subjective and interactive researcher role predominates, the language employed to present the research processes and results describes the *rhetoric structure*, which flows closely from one's epistemological and axiological stance (Ponterotto, 2005). It is therefore important to elucidate that the current project, which was conducted from an existential-phenomenological perspective, was written in the first and not the third person narrative for very specific reasons which lie at the core of phenomenology (e.g., Finlay, 2011). Such an approach is in line with seminal phenomenological approaches such as that of Husserl (1925/1977) who opened up the way to phenomenology as the reflective study of structures of consciousness as experienced from a first-person perspective. As the narrator in this research project, I was justifiable as an active agent in establishing with all co-researchers the dependable research findings by reflecting together about shared meanings, as human beings interested in the explored phenomenon of working at a relational depth with people that had been given a diagnosis of psychosis. It would have therefore been incongruent to engage in a de-personalised third person narrative and instead, written in first person narrative, this thesis reflects a more authentic outcome, congruent with the chosen epistemological and ontological position, which will be unpacked in the introduction.

INTRODUCING THE AUTHOR

This section aims at introducing the reader to my personal journey in the training of counselling psychology and existential psychotherapy and my work experience in psychiatric settings in order to explain how my personal and research interest in the field of psychosis has progressively formed itself and led to the development of the current project. Moreover, this section is vital in the sense that from a qualitative and more particularly a phenomenological research vantage point, the position from which one speaks should be as thoroughly reflected as possible in order to acknowledge pre-conceptions and how previous lived experiences can influence the research process overall.

Before I commenced postgraduate studies in counselling psychology (CoP), I completed undergraduate studies in social sciences and psychology. My undergraduate years required a great level of involvement with the empirical and scientific principles of the psychological-scientific model, which emphasises the objective and the measurable. My involvement with this logical-empiricist perspective gave me the opportunity to appreciate the scientific demand for rigorous empirical enquiry focusing on traditional psychology, but likewise, I felt that the empirical methodologies for understanding and exploring the human experience were narrow and monodimensional. It therefore felt necessary to choose a postgraduate training within applied psychology that would endorse a more pluralistic attitude with recognition and validation of multiple perspectives in theory and practice, whilst also integrating psychotherapeutic training. The consideration of selecting pure psychotherapeutic training did not appeal to me at the time, as I was deeply interested in exploring qualitative and phenomenological research methods from a psychological platform. CoP seemed able to combine psychology and psychotherapy in a tantalising fashion. Its pluralistic, anti-dogmatic standpoint and commitment towards the subjective experience and the possibility for its significant contribution to the understanding of human existence attracted me greatly. My decision to train as a counselling psychologist (CoPt), particularly within the existential-phenomenological paradigm, therefore gradually became clear.

In the process of reflecting about how past experiences have contributed to the formation of my decision to choose the existential-phenomenological school of thought, it was impossible to ignore memories of my early schooldays. The high school curriculum back in Cyprus (where I come from) included weekly readings, comprehension and analyses of ancient Greek tragedies by writers such as Aeschylus, Sophocles, and Euripides. Their narratives of great suffering and transience and their imperative of growth through suffering were early intimations of existential attitudes and dilemmas since their central concerns were problems related to human existence. These tragedians advocate saying yes to life even in its strangest and most painful experiences. Although I was unacquainted with existentialism back in those days, the explicit exposure to existential works in adulthood rekindled a nameless passion and framed pre-existing knowledge. Poring over existential philosophy books in early adulthood gradually became my new retreat. My passion for world literature and cinema were a crucial factor in the development of my philosophical background. Favourite film directors such as Ingmar Bergman, François Truffaut, Jean-Luc Godard, Michelangelo Antonioni, Akira Kurosawa, Andrei Tarkovsky, Krzysztof Kieslowski and many more certainly demonstrate the richness of an existentialist interrogation of meaning and purposefulness of action in the world, and contemporary cinema continues to prove a fertile area for philosophical enquiry. In addition, writers such as Albert Camus, Fyodor Dostoyevsky, Franz Kafka, Samuel Beckett, William Shakespeare, Hermann Hesse, Oscar Wilde, Haruki Murakami, Leo Tolstoy, George Orwell and Simone de Beauvoir whose works accompanied my early adult years, demonstrate philosophical concern in the actions and choices of their characters, and through the medium of art exemplify their understanding of existentialist philosophy. The existential-phenomenological approach to CoP and its devotion to phenomenological models of research and practice and its interest in consciousness, subjective experience and inter-relationship appeared therefore greatly alluring and aligned with my personal interest in existential philosophy.

The same month I commenced my postgraduate training in existential CoP and psychotherapy I also started working on an acute psychiatric unit in the National Health Service (NHS) as a mental healthcare worker, a position I held for a continuous period of three years. My decision to apply for this particular post was

mainly guided by my curiosity to witness how people who experience severe distress are treated and understood in psychiatric settings, and also to explore the severity and manifestations of human distress. However, later reflections resulting from my clinical work with psychosis provided me with the opportunity to consider how this decision was also influenced by a deeper need to explore my own depths of anxiety and anguish. My main responsibilities involved the development and maintenance of therapeutic relationships with in-patients as part of the on-going assessment and care delivery process, and ensure relevant information was reported to the rest of the team. Other responsibilities involved contribution and participation in the assessment, planning, implementing and evaluating of care and 'treatment' in the ward environment and assisting in the delivery of therapeutic programmes.

The concurrency of my exposure to theoretical material and discourses on critical approaches to psychiatry and 'psychopathology' from a philosophical and existential-phenomenological vantage point (e.g., Du Plock, 1995; Foucault, 1988; Gallagher, 2004; Laing, 1965, 1967; Sass, 2000; Sass & Parnas, 2006; Stanghellini, 2004; Szasz, 1979) throughout my CoP training, and my lived experiences on the psychiatric ward, gradually formed a tension within, which took me a while to contain and make sense of. However, my efforts to contain and make sense of the effervescing tensions among the two dynamic platforms and the discourses to which I was exposed (mainstream psychiatric versus the existential-phenomenological) gradually shaped my research question. I felt deeply challenged in my efforts to embrace an attitude to psychopathology that could still allow me the appropriate space to reflect the basic humanistic value of my personal philosophical position by emphasising clients' lived experiences. The philosophical backbone of my CoP training that was informed by the phenomenological tradition was aligned with this view, by emphasising 'well-being' instead of notions of pathology (Strawbridge & Woolfe, 2003). As Woolfe (1990) has emphasised, CoP places a great emphasis on the phenomenological: "(…) one of the primary contributions which CoP has to offer psychologists is the value it places on the subjective experience of its clients. The sharing of this inner reality helps to cement the relationship between client and helper and acknowledges the importance of each individual's construal of life experiences" (p. 532).

The psychiatric environment on the ward where I was employed had the typical approach of classifying clients into 'disorders' and embracing the symptom-and-diagnosis-focused approach epitomised by the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This is a medical model approach to human distress, which embodies the fundamental assumptions of positivist-empiricist science such that human distress can be justifiably and precisely categorised (Boyle, 1999), which has been significantly critiqued (e.g., Bentall, 2003; Boyle, 2002; Bracken et al., 2012; Fee, 2000; Johnstone, 2008). My passionate engagement with clients and colleagues on the ward gradually generated several questions and reflections: What could I possibly offer as a trainee CoPt within an inpatient psychiatric setting? What could I possibly offer as a chartered CoPt in the near future to people whom I felt were trapped and re-traumatised in inpatient psychiatric services? But most of all, what was it like to form close relationships with individuals who had been diagnosed with psychosis, where this possibility of the formation of relationships felt to me sabotaged by the exaggerated and oversimplified conception that it remains tremendously challenging if not impossible?

My basic responsibilities on the ward provided me with a great opportunity to spend a considerable amount of time with clients and establish close relationships with many of them, which was significant for my curiosity to explore and make sense of severe distress and particularly the manifestation of psychosis and its meaningfulness. The ward manager, who had witnessed my passion in working attentively with clients, soon invited me to take over more responsibilities while supporting me in receiving further training related to multifaceted issues in working with psychosis. My intense involvement on the ward provided me the opportunity to approach mental health and wellbeing in a holistic fashion. My responsibilities provided the opportunity to explore what clients were going through, how psychosis subjectively emerged for people in heterogeneous ways, how they experienced themselves and others around them, how they experienced me in trying to make sense of their own experiences but also how their milieu experienced them and responded to their difficulties. It is therefore without doubt that my research project was gradually inspired within these subjective and intersubjective dynamics.

INTRODUCING THE RESEARCH PROJECT

This research project investigates the experiences of CoPts' and psychotherapists, who identified themselves as coming from a relational-intersubjective standpoint, working with individuals who have been diagnosed with psychosis. The scarce literature on the experiences of CoPts working with this client group, and also my awareness as a trainee CoPt of a growing body of negative literature about psychologists, psychiatrists and psychotherapists' difficulty in working with this client group (e.g., Hinshelwood, 2004; Jackson, 2001; Midence, 2000; Dennis, 2000) have also been a significant influence on the development of this project. My review of the UK CoP literature revealed that there were only a few articles and doctoral theses written by/for CoPts on working with individuals diagnosed with psychosis and very limited literature within the CoP field on working with this particular group. Frequent and systematic searches within a range of psychology databases confirmed this to be the case (e.g. psychINFO). My preliminary objective was to exclusively explore the experience of CoPts working therapeutically with individuals diagnosed with psychosis. Prior to arriving at the final phase of giving shape to my main research question and deciding upon my participants, my initial idea went through a series of revisions. The potential difficulties in recruiting CoPts who meet the inclusion criteria due to expected shortage (e.g., Larsson, Loewenthal, & Brooks, 2012) were confirmed after the first stages of identification, targeting and enlistment of possible participants. The response rate was significantly low from the very beginning of the recruitment process until its completion. After careful revisions, I finally decided also to include psychotherapists from different modalities who identified themselves as working from a relational/intersubjective vantage point. It is significant to clarify that in the process of revising my inclusion criteria I considered the 'relational' approach of practitioners as a more significant factor in working intersubjectively, as opposed to imposable therapeutic techniques (e.g., Geekie & Read, 2009). By including a gamut of background training and therapeutic orientations, I assumed a more comprehensive understanding of the explored phenomenon and an association with the existing literature, to facilitate applicability and dissemination.

SITUATING THE AUTHOR WITHIN THE PROJECT

The origins of the project's early inspirations are considered as an inextricable section of the personal reflexivity dimension, an intentional position that will be employed throughout the project. It should be noted here that incorporating a self-reflexive position throughout the research process has been a significantly fertile yet challenging task. As has been argued by Kidder and Fine (1997), subjectivities must be "(…) acknowledged, studied, interrogated and written about" (p.40). Finlay (2002) suggested that such an attitude helps the researcher to transform subjectivity in research from a potential problem to an opportunity. Gadamer (1960/1996) has also emphasised that in the process of exploring and trying to understand phenomena in qualitative research, the process of self-understanding remains significant since we are always speaking and exploring from a position contingent on our personal history. Even though a Gadamerian hermeneutic approach has informed the research process of this project as I have been thoughtful of my own lived experiences and personal history related to the explored phenomena, this was accompanied by the appropriate bracketing which will be discussed later.

My working background and experiences in psychiatric settings have significantly influenced and set the basis for this research project, hence encompassing a biographical influence (e.g., Harper, 1999) in the formation of my research proposal in the early days. It should therefore be clarified that the following remarks are reflections of my own intersubjective experiences and therefore idiosyncratic in nature. Moreover, the context of CoP training itself has also been a significant factor which provided the appropriate atmosphere, conducive to critical research. As has already been stressed, the philosophy of my training was based on existential-phenomenological philosophy and it provided me with the opportunity to appreciate and identify with existential-phenomenological (e.g. Deurzen-Smith, 1997), post-existential and postmodern approaches to counselling and psychotherapy (e.g., Loewenthal, 2011), a focus on intersubjective approaches to psychology and psychotherapy (e.g., Frie, 2003; Frie, 1997) and critical approaches to psychopathology and psychiatry (e.g., Sass, 1994; Thomas & Bracken, 2004).

The mental health trust I have worked for has in recent years introduced the provision of talking therapies for clients receiving treatment within inpatient settings, including family therapy, individual cognitive-behavioural therapy, psychosocial interventions and weekly group therapy adjusted for psychosis. The introduction of these services was part of the latest developments within the UK mental health sector, which has begun to consider recovery and living well in the presence or absence of one's 'symptoms' as the optimum outcome for people, rather than understanding stabilisation (National Institute for Clinical Excellence, 2009). Additionally, recovery is progressively conceptualised on an international level as not simply the reduction and treatment of manifested 'symptoms' or achievement of psychological milestones. It is also seen as encompassing positive transformations in how people reflect on and experience themselves as individual human beings in the world, changes that may occur irrespective of whether they experience other improvements in symptoms or function (Silverstein & Bellack, 2008).

Although this has been a noteworthy shift and albeit the aforesaid provision of services can be integrated into the clients' treatment plan on a voluntary level, clinical interventions involving the administration of psychotropic medication still dominate the treatment of severe human distress. More specifically I observed that the enforced administration of psychotropic medication for individuals sectioned under the Mental Health Act (Department of Constitutional Affairs, 2007) restricted their volition on many different levels. When clients were not compliant with their medication they were explicitly considered incompetent in making decisions regarding their own treatment. I have often questioned the value of encouraging the client towards a relational and intersubjective option (talking therapies) when they seemed objectified into a complex 'accumulation' of symptoms. How can a person assume a purposive striving towards a talking therapy when she is simultaneously considered incompetent in making decisions for her treatment in the often-presented case of refusing medication? How can we consider the manifested avolition in hospitalised people as independent from the rationale of their hospitalisation? I witnessed various implicit and explicit conflicting demands placed upon clients during their hospitalisation (e.g. freedom to choose a form of talking therapy versus the enforced psychotropic medication), which often brought to mind the concept of the Bateson's *double bind*

which has been hugely neglected in the literature and deals with the conceptualisation and understanding of psychotic experiences. Bateson (1972) suggested that these conflicting demands might lead a person to further confusion in their thinking processes and may appear incapable of confronting it at length. In view of Bateson's *double bind* hypothesis, the solution for the client is then to create an escape from the conflicting logical demands of the double bind, in the subjective world of a delusional system.

EXPLANATION OF MAIN CONCEPTS

It is essential to briefly introduce the reader to the concepts of both psychosis and intersubjectivity, which constitute the principal exploratory emphases within this research attempt. Psychosis in the mainstream psychiatric/psychological literature and diagnostic manuals is a broad term described as a bundle of clinical symptoms presented accordingly in several diagnostic categories (e.g. schizophrenia, schizoaffective disorder, bipolar disorder, delusional disorder, etc.), which include *hallucinations*, *delusions*, *thought disorders*, *disorganized* or *anomalous speech, flat/inappropriate affect, avolition, apathy, disorganized behaviour, catatonic motor behaviour, depersonalization* and *derealization* (Ban-Thomas, 2001). This project does not comprehend these experiences as pathological states or symptoms of a single form of acute distress but instead considers them as meaningful and context-sensitive experiences. By employing an E-P approach, this project understands the phenomenon of psychosis as a meaningful alteration of intentionality and self-experience, and also as a transformation of Other-experience and disembodiment. The literature review is not particularly interested in exploring the causations/aetiology of the manifold phenomena of psychosis but instead is interested in making sense of their meaning by approaching them as a way of being-in-the-world. Additionally, from a phenomenological perspective, psychosis is not conceived as a pathological condition which happens within the person but one that occurs between the person and the world.

Intersubjectivity cannot be exhaustively defined within a single paragraph or chapter, as it is an extremely complicated concept that can be approached from several philosophical, sociological, and psychological perspectives, even from within a single epistemological framework. Furthermore, although various E-P thinkers have directly or indirectly addressed the problem of intersubjectivity, in subsequent sections I will be emphasising those whose contributions are considered more in line with this project's epistemological position and pertinent to the understanding of psychosis and its psychotherapy (Binswanger, Merleau-Ponty, Buber, Scheler) while critically reviewing others (Sartre, Heidegger, Husserl). A particular emphasis will be placed upon Buber's dialogical philosophy and how his analysis of the *ontology of the between* (Buber, 1921/1996) can contribute towards a clinical understanding of an *I-Thou* intersubjectivity in therapeutic work with psychosis. Intersubjectivity in this sense emphasises the significance of reciprocal relatedness and the emergence and unfolding of selfhood as contingent upon dialogue, which is situated between separateness and relatedness in the therapeutic process. Even though one can often locate references in the psychological and psychotherapeutic literature conflating empathy with intersubjectivity, it is important to remark that the two are not indistinguishable concepts. Zahavi (2001) distinguished between intersubjectivity and empathy and emphasised that intersubjectivity does not exclusively concern concrete face-to-face interactions or the thematic interchange between two persons, where one is trying to comprehend the emotions or experiences of the other. Intersubjectivity is therefore not only to be understood in its ontic but in its ontological and transcendental forms and involves the multifaceted interactions between subjectivity and the world. In other words, it is interested in the intersections of self, others and the world. In a subsequent section, I will explain in more detail how this project mainly emphasises the form of intersubjectivity which endorses the second-person perspective.

SYNOPSIS

A substantial amount of psychological and psychotherapeutic literature emerging from a plethora of theoretical standpoints emphasises the significant difficulties people diagnosed with psychosis present in their interpersonal engagement with others (e.g. Davidson, 2003; Fromm-Reichmann, 1950; Kline, Horn, & Patterson, 1996; Lysaker, Wickett, Wilke, & Lysaker, 2003; Searles, 1965; Sullivan, 1962). However, despite the plurality and diversity in the psychotherapeutic literature which stresses the aspects of the psychotic state and its 'distorted' intersubjectivity, there has been an underestimated inclination towards the exploration of psychotherapists' self-experiences and challenges within the intersubjective space of psychotherapy and the ways in which these affect the therapeutic process and outcome. Even though diverse psychoanalytic discussions regarding the countertransference involved in the psychotherapy of psychosis have considered the vulnerability of the therapist (e.g. Searles, 1965), it is conceived in a dissimilar way than from an intersubjective and relational perspective. As Cohn (1997) has addressed, in the psychoanalytic view of the therapeutic relationship the emphasis is on transference and countertransference with a preference towards an impersonal space and a need for anonymity without considering the place of the 'real' relationship the intersubjective perspective addresses. However, a growing body of contemporary psychoanalytic theorists and practitioners address the significance of real engagement between client and therapist with an emphasis on the therapist's openness in the therapeutic space (e.g. Stolorow, 2013) and this will be therefore considered.

From an intersubjective point of view, it is impossible to negate the possibility of a failure of the therapist to meaningfully engage with the person presenting psychosis. Someone might rightly suggest that the person in the psychotic state might invite the therapist to engage with a deeply disturbing aspect of herself, in a manner that might sabotage the intersubjective space in-between. We cannot, therefore, assume that therapists are solely defined by an indisputable capacity for reciprocity and dialogue. If we consider that psychosis manifests as a 'pathological' form of intersubjectivity which has a relational 'dysfunction' of self in relation to self and

Other (e.g. Kimura, 1982), we cannot assume the therapist's intersubjectivity 'wholeness'. In the case of individual psychotherapy, it cannot ever be 'whole' as it consists of two subjectivities that are held in a relational tension and are mutually influencing each other. Someone may also argue that within the therapeutic process of psychotherapy for psychosis the 'deficient' intersubjectivity also occurs due to a failing engagement from the professional's side. Based on my lived experience, the therapeutic engagement with psychosis provides the opportunity to shed light on personal difficulties in engaging with otherness and these experiences have therefore emerged as a powerful initiative in this research project. Along similar lines, below I provide a quote from Rumke (1941/1990, p.336) who paid close attention to the abovementioned processes and portrays clearly how these are thought of from a phenomenological perspective:

> *As interpersonal relations are not one-sided, the investigator examining a sufferer from schizophrenia notices something out of the order within himself. What is wrong is then not just the emanating feeling, but a sort of destabilization: when establishing an encounter, we usually 'lean into' a relation, which is stabilized by the process of interaction and reverberation that usually gains its own autonomy. We project ourselves and create a common space and our mode of self-relation that characterizes such projection depends on the autonomy of the smooth-exchange.*

CHAPTER 1: INTRODUCTION

1.1 AIMS OF THE RESEARCH PROJECT

In accessing my participants' lived experiences, I have employed a phenomenological paradigm and in particular the methodology of *Interpretative Phenomenological Analysis* (IPA) (Smith & Osborn, 2008), with the objective of gaining access to their subjective experiences in the context of their work with people that have been diagnosed with psychosis. A particular focus was placed upon the intersubjective elements of the therapeutic processes involved, in order to shed light on the clinical implications of working intersubjectively with psychosis, and provide directions for further research both within the CoP and existential psychotherapy fields, but also in the wider psychotherapeutic community. These particular research priorities have not yet been explicitly explored within the CoP literature, and it was hoped that this research could contribute to a severely neglected area in the field. While I was initially interested in exclusively exploring CoPts' experiences, after revisions I finally decided to include psychotherapists in my sample. With the multifaceted challenges of working therapeutically with psychosis being recognised, embracing a gamut of background training and orientations offered a more comprehensive understanding of the phenomena (and therapists' stances towards them) and the linkage with the extant literature, in order to facilitate widespread applicability and dissemination.

1.2 EPISTEMOLOGICAL POSITION

Although I will thoroughly address the topic of epistemology in the methodology chapter, it feels vital at this point to summarise my epistemological position with regards to the current research initiative. Having being trained by choice as a CoPt within the E-P paradigm, my passion and commitment to this particular philosophy have influenced the way I have positioned myself within this paper with

all the accompanying roles of the researcher, interviewer, narrator, and writer. Although there are many ways to approach psychosis, my intention has been clear from the very beginning: to approach it from an E-P position as a becoming-counselling-psychologist, less concerned with the origins or aetiology of psychosis but mostly focused on practitioners' lived experiences.

I zealously consider that I have conducted a valuable piece of research that is of direct benefit to both CoP and psychotherapy and particularly to clinicians who work with people diagnosed with psychosis. Having employed a phenomenological research method, it is important to note that I acknowledge the possible biases within the research process itself and the final results which are, as McLeod (2001) explained, always influenced by the researcher. He also states that it is impossible to separate oneself from the research in order to be an entirely neutral investigator. Similarly, Finlay (2008) emphasised that a researcher who attempts an objectivistic, distanced or detached attitude sabotages the phenomenological approach. I have therefore tried to be as vigilant and reflective as possible and have tried to orchestrate the appropriate level of proximity and distance in order to represent my participants' experiences of the explored phenomena as authentically as possible.

1.3 SUMMARY OF CONTENTS

It should be primarily noted that all terminology employed will be thoroughly defined and presented within the epistemological and ontological frameworks in which this study was conducted. The literature review will commence with exploring psychosis from the phenomenological angle through early E-P and contemporary phenomenological approaches. An exploration of intersubjectivity through the lens of phenomenology will proceed by placing emphasis on intersubjectively informed psychotherapeutic approaches. Moving on, I will proceed with a thorough engagement with the chosen methodology and methods. Given the selection of IPA as the method of analysis, engaging thoroughly with methodology is crucial given IPA's commitment to phenomenological description and interpretation. The analysis of data

proceeds with a clear exposition of participants' accounts and the process of organising and analysing them into themes. In the discussion chapter, I attempt to evaluate the results in light of the literature review by presenting additional literature that has been considered appropriate. The discussion connects the conclusion to the rest of the project including clinical and methodological considerations, limitations of the research and shedding light into the possibilities for future research in the area of interest. It should be specified that due to the limitations of space, the following sections are not as comprehensive as I would have wished for. Nonetheless, I anticipate that the relevant information and presented results will be sufficient to engender additional enquiries and discussion regarding the chosen research area.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This section will attempt to include the most significant issues relevant to the research question through an integrated exploration of the existing literature by focusing significant attention on current epistemological and ontological arguments. The intention here is to prepare the reader for the rest of the research, which will concentrate on the subjective experiences of CoPts and psychotherapists working intersubjectively with psychosis. It is important to stress that CoP's association with diagnostic categories such as psychosis has received little consideration in the literature. More specifically, CoPts' experiences who work with people diagnosed with psychosis have not received the appropriate attention and therefore exploration of the nature of the therapeutic relationship from a CoP vantage point and a detailed emphasis upon the intersubjective dynamics inherent in the therapeutic process appear vital. The review will initially attempt an exploration of the phenomenon of psychosis by focusing on fundamental phenomenological notions such as intentionality, embodiment, temporality, subjectivity and intersubjectivity. A consideration of the literature on the psychotherapy of psychosis and the early contributions from the existential-phenomenological paradigm through the lens of intersubjectivity will then proceed.

2.2 PSYCHOSIS

2.2.1 Approaching psychosis phenomenologically

Among the plethora of approaches available in understanding and working with psychosis (psychiatric, psychological, psychosocial, psychodynamic, psychoanalytical, etc.), I am committed to approaching it from the E-P angle, and therefore interested in the essence of how psychosis manifests and is subjectively

experienced but most importantly how it reflects a particular way of relating to the world. From an E-P perspective, this particular emphasis on lived experience exceeds the endeavour to explore the origin of phenomena in the clinical setting. Instead, there is an emphasis on how the experience has been transformed and how the person experiences and describes this transformation. Moreover, understanding the lived experience does not necessarily involve the comprehension of the causes. For these reasons, the aetiological literature will not be explored in the literature review.

Aside from the idiosyncratic influences which have been unpacked in the preface, I undertake that it is important to introduce and answer the following question as transparently as possible: Why is it important to engage in phenomenological explorations of interpersonal relating in working therapeutically with severe forms of distress – and more specifically with psychosis – from a CoP perspective? Perhaps, the most substantial reason is that CoP as a division of applied psychology, undoubtedly rooted in the phenomenological tradition (e.g. Woolfe, 1996), is primarily interested in the formation of intimate therapeutic relationships and making sense of otherness in the process. We may also undeniably argue that the development of an effective clinical practice is partially contingent on being able to hold a reflective attitude towards the multidimensional manifestations of intersubjectivity within the therapeutic space. Moreover, philosophical and phenomenological frameworks affect the way we think about and critically evaluate psychiatric disorders from a CoP perspective. What is also significant is that phenomenological explorations may be of direct clinical importance to CoPts working with psychosis given that phenomenological approaches of other-awareness and self-awareness suggest different potential ways of constructing therapeutic approaches in the psychotherapy for psychosis (Lysaker, Glynn, Wilkniss, & Silverstein, 2010).

Even though this chapter employs an E-P approach in attempting to describe and make sense of psychosis and relevant phenomena, I am not suggesting that these phenomena can apply to all persons who are diagnosed with psychosis (e.g. Bentall, 1993). Strict diagnostic tendencies and the inclination to generalise research findings on particular clinical phenomena for specific groups are attitudes that both CoP and the E-P paradigm seem to challenge. Along these lines, Parnas, Nordgaard & Varga

(2010) suggested that since psychosis is a descriptive term with no biological indicator of its presence and taking into consideration that a person is always situated within a specific existential context, it appears impossible to provide a reliable, context-immune list of symptoms for psychosis. Psychosis, therefore, cannot be understood outside and independently of the contextual, psychological and existential circumstances of a person. Briefly speaking, this project will approach psychosis as an altered state of self-awareness and other-awareness that results from a person's way of *being-in-the-world*[1] (Heidegger, 1926/2001). I will therefore embrace an approach of a deeper phenomenological reflection of the psychotic position of being-in-the-world, by examining its existential condition, and look for the way in which the structure of meaning may be uncovered. The strand of phenomenology this project endorses attempts to comprehend and conceptualise phenomena in the closest possible accordance with how a person actually experiences these phenomena. Even though I will provide a description of the phenomenal features of psychosis as they have been described and conceptualised by early and contemporary phenomenological studies, I will not restrict the content of this chapter to such a description. Phenomenology is not merely a method of taxonomy or nosology that seeks to form operational definitions (Mullen, 2007), despite the fact that some of its earliest attempts in approaching clinical phenomena have retained and cultivated these methods. This is exactly why some of the earliest phenomenological approaches to psychosis, and particularly Jaspers' 'Descriptive Psychopathology', have failed to comprehensively approach severe distress. Greatly influenced by Edmund Husserl's phenomenological project, Jaspers laid the methodological foundations of descriptive psychopathology in psychiatric research and practice (Hafner, 2015). Jaspers adopted a sound phenomenological approach in gaining knowledge about psychopathological states and placed particular emphasis on encouraging patients to describe the phenomena presented in their consciousness as accurately as possible, while he also suggested that the psychiatrist's main endeavour should be directed towards an accurate reproduction of the patient's mental phenomena in order to re-examine their interrelatedness (Jaspers, 1959/1963). While in his earlier work he was more open to an empathic grasping of the patient's mental life in meaningful terms, his later work

[1] Being-in-the-world is the foundational and existential a priori state of Being according to Heidegger. In his ontological project self and the world are inseparable and are grasped together in the sense that to exist as a human being is to coexist (Heidegger, 2001).

used Freud's psychoanalytic, Daseinanalysis' and anthropological psychiatry's approaches in attempting to ascribe meaningfulness to psychotic states discordant with his own project, and he openly criticised all of these attempts in approaching psychosis as a comprehensible condition. Although Jaspers' earlier work placed greater emphasis on the subjective experiences of people diagnosed with psychosis and strongly suggested that psychiatric symptoms should be approached with empathy, he nevertheless in his later work described psychosis as an incomprehensible state, which should be treated psychiatrically and not psychologically or psychotherapeutically. From an E-P intersubjective perspective, Jaspers' approach to psychosis seems therefore problematic since it negates the possibility that a person's psychotic difficulties could be understood by closely examining her personal history and the structural components of one's being-in-the-world, while also rejecting the possibility that insight into a person's mental life can be achieved by intuitively and empathically attuning to their experiences. However, Jaspers (1959/1963, 1912/1968) offered a sound philosophical and phenomenological interpretation of psychiatry's theoretical and clinical elements, by offering comprehensive descriptions of 'normal' and 'pathological' functioning.

Before proceeding, I consider it important to briefly describe the strand of phenomenology I will be employing in attempting to comprehend the phenomena of interest since phenomenology is a complex and heterogeneous school of thought with its fundamental philosophy characterised by an internal diversity. Bovet and Parnas (1993) have distinguished between three common uses of phenomenology in the exploration of clinical phenomena. The first one, common in Anglo-Saxon psychiatry, endorses phenomenology as part of a descriptive psychopathology, which mainly involves the pure description of psychiatric symptoms. Jaspers' seminal works (e.g. Jaspers, 1949/1963) inform the second approach which is descriptive and concentrates on the patient's inner world and experiences, which can only be understood through her own narrative with the practitioner reproducing the patient's experience by quoting her self-descriptions. The third approach, which this project endorses, is based on existential-phenomenological philosophy (e.g. Husserl, 1936/1970; Heidegger, 1926/2001; Merleau-Ponty, 1945/1962; Gadamer, 1960/1996; Sartre, 1943/1956; Buber, 1921/1996) and is interested in identifying, describing and

attempting to understand the essential features of being-in-the-world through the person's intentionality. Intentionality, which is a core concept in phenomenology, refers to the directedness of consciousness and considers that we are always conscious of something with our subjective experience directed toward that which is external to the self (Davidson, 2002). Merleau-Ponty (1945/1962) suggested that what remains significant when investigating intentionality is the sensing of meaning. He suggested that in order to understand human consciousness and its world we must commit to exploring the subjective experience and its intentionality and to reveal the meaning of all human phenomena within that lived experience. This approach endorses a systematic phenomenological investigation of subjectivity and intersubjectivity from the first and second person perspectives. In the sections that follow I will present how early E-P approaches have conceptualised psychosis, followed by an explanation of contemporary phenomenological approaches, and ending with an alternative approach grounded in intersubjectivity and a dialectical understanding of intentionality which emphasises the intersubjective constitution of self-awareness.

2.2.2 Early existential-phenomenological approaches to psychosis

Some of the most prominent figures in the early E-P conceptualisation of psychosis include *Merard Boss, Ludwig Binswanger, Eugene Minkowski, Ronald Laing and Wolfgang Blankenburg*. They, amongst others, gave rise to the so-called *anthropological psychiatry* and their thinking challenged the neurologically focused conceptualisations of schizophrenia and psychosis by providing some phenomenological and existential insights. Even though their contributions have been influential in both the conceptualisation of psychosis and the development of psychotherapeutic approaches in the first half of the last century, their insights are rarely considered in contemporary E-P approaches to psychosis, let alone the broader psychotherapeutic literature. A brief overview of their contributions will be attempted in the current section.

The phenomenological psychiatrist Ludwig Binswanger and existential psychiatrist Merard Boss represented the *Daseinsanalysis* approach and applied philosophical concepts to their psychiatric work with their contributions considered as the earliest comprehensive attempts to apply existential phenomenology to psychotherapy (Frie, 1997). Their main endeavours were to explore meaning in what might at first appear as irrational or 'mad,' and they were both leading figures in sketching an existential approach towards psychosis and schizophrenia. Firstly, Binswanger (1963/1993) did not completely reject the possibility of a biological basis of psychosis, although he placed his emphasis on the person's relations with the world and others. He considered that every person has a particular *world design*, a particular way of perceiving the world that is structured a priori and therefore not dependent on life experiences. He suggested that no particular traumatic experience could result in any form of psychopathology if a specific world design had been absent. This existential a priori was one of his main interests in exploring the psychological structure of psychosis. He considered the person who experiences psychosis as someone who develops an exaggerated relationship with reality and gradually experiences tremendous anxiety, despair, and meaninglessness. Binswanger introduced Heidegger's and Buber's philosophical approach to human relating and applied them to psychotherapeutic work under psychiatric conditions. He emphasised the importance of paying close attention to the subjective nature of any manifested phenomena by highlighting the importance of finding out what a person meant by a symptom. Being greatly influenced by Heidegger's ontology and his notion of being-in-the-world, he conceptualised psychotic experiences as a form of modification of the structural components of one's basic being-in-the-world (the essential structures of human existence such as *temporality, spatiality, being-with* etc.). Binswanger (1963/1993) understood in Heidegger's being-in-the-world an essential interpretation of human relatedness, although he criticised Heidegger for not dealing sufficiently with the interpersonal aspect. He suggested that any therapeutic understanding and conceptualisation of psychosis could be located within the relationship between the therapist and the client. However, one of the main criticisms Binswanger's existential analysis of psychosis and other psychiatric conditions attracted (also from Heidegger himself (1954/1968)) was that his approach was more ontic than ontological. He concentrated more on how a particular human being responds to the world and others

and was greatly interested in a person's ontic and a priori world design without examining for its ontological significance. More specifically, he did not consider basic *existentials* such as *being-towards-death* and one's *thrownness*[2] in the world or how embodiment is involved in particular psychotic symptoms. Additionally, his emphasis on the significance of individual world designs on the manifestation of psychotic phenomena seems restrictive and paradoxical considering the significance he placed upon a person's relations with the world and others. Even though he strongly suggested that no particular traumatic experience could generate psychopathology, a plethora of research findings suggests a significant association between early traumatic experiences and the emergence of psychosis (e.g. Conus, Berk, & Schafer, 2009), which put his assumptions into great dispute. Nevertheless, as Koehler (2004) has emphasised, he was a pioneer in establishing a non-reductionist approach to human suffering and distress and more importantly in tackling the issue of intersubjectivity in therapeutic work with psychosis.

Boss (1963), on the contrary set up a more ontological project for the conceptualisation of psychiatric conditions and particularly for psychosis. He claimed that people's hallucinated and delusional subjective realities should be taken very seriously by considering them as manifestations of Dasein's[3] disclosure. In approaching withdrawal, delusions and hallucinations, Boss (1979) presented the notions of the *erecting of barriers* and the *dismantling of barriers* as features of a disturbed capacity to respond to the world. He described how the person in the process of erecting barriers gradually withdraws from her relational context, while in the state of dismantling barriers the person is gradually led to delusions and hallucinations because her intersubjective reality is experienced as very powerful and concrete. Boss (1963) in his Heideggerian approach to psychosis suggested that the withdrawal from the relational context relates to the disturbances in the fluidity of affectivity and it is related to deformations of temporality. More specifically, Boss

[2] Heidegger (1926/2001) with the term thrownness refers to the fact that existence from its very start is found thrown within a particular factical situation with no personal choice involved

[3] 'Dasein' is a German word which translates into "being there" and was a fundamental expression introduced by Heidegger (1926/2001) to refer to the experience of being and existence

(1963, p.235) understood psychosis as a disturbance of the specific being-in-the-world:

> (*...) which is the nature of human being. This Being-in-the-world is the carrying, sustaining, maintaining, and holding open of that a clear worldly realm of perception and responsiveness that all people carry out, though each in his own individual way*

Even though he was a pioneer in providing a unique ontological understanding of psychosis, he neglected to deal sufficiently with the ontic component. Moreover, even though he introduced and analysed phenomenological and existential concepts in understanding psychosis, he did not deal with the phenomenological method as such and its possible application to psychotherapy for psychosis.

Similarly to Boss and Binswanger, Minkowski (1970) was another significant contributor to the field of psychosis who positioned the human being at the heart of his approach and understood psychosis as affecting the totality of a person. Apart from his consideration of the person's subjective experience, he was the first to introduce the notion of time and temporality in psychopathology. He also made links to core phenomenological concepts such as embodiment, intentionality, and intersubjectivity. He considered temporality as a central and multidimensional type of intentionality, involved in almost every part of conscious human life. Minkowski explored distorted *lived time* and its significance in the manifestations of psychosis and how certain psychological difficulties are associated with particular experiences of time. He associated the distorted consciousness of time in psychosis with the directedness of the experience of lived time by relating it to disturbances in self-experience. Disturbances in self-experience and world experience in psychosis result in a *loss of vital contact with reality* according to Minkowski, leaving the person not able to integrate her experiences, which results in difficulties in sustaining a sense of self. He conceptualised the loss of vital contact with reality as being associated with a loss of a bodily openness of being-in-the-world. Similarly to Boss, he suggested that the intersubjective difficulties that develop in psychosis are presented long before core psychotic symptoms arise and that alterations in self-experience which are

essential for the development of psychosis already exist early in life. By introducing his term *lived synchronism* he clarified how essential temporality is for a person's intersubjective relations and attunement to the world by being temporally connected with others in the same intersubjective time.

Greatly influenced by the movement of Daseinanalysis and particularly by Binswanger, Laing (1965) also acknowledged that biological factors could predispose a person to psychosis; however his project mainly revolved around the conceptualisation of self in psychosis. He clearly asserted that the person with psychosis withdraws from autonomous selfhood in striving to survive a potential obliteration and that her psychotic experiences consist of meaningful attempts to deal with the world and others. For Laing, vulnerability to psychosis was linked to a fundamental sense of *ontological insecurity*, which he defined as the state where the person's sense of self and identity are unstable and her sense of reality insecure. According to Laing, being unable to take for granted her identity, the ontologically insecure person fears *engulfment* (autonomy will be destroyed by others' intentions), *implosion* (the real world and others can cause a disintegration of self) and *petrification* (the other has the power to cause depersonalization and turn one into an inanimate object). Laing also wrote extensively on how the family and social systems affect the development of these fears through the invalidation of experience and the communication of ambiguous messages by asserting how these systems intersubjectively affect the development of individual consciousness. Laing's understanding of intersubjectivity emphasised how a person is intertwined and enmeshed in the world with others. It is upon this condition that he considered that the formation of self is a process that never completes. In the case of psychosis, he explained how the person is deeply enmeshed with others to the extent that she cannot develop a centre of direction by being overwhelmed with a sense that others inhabit her thoughts or that she cannot separate her will from their intentions, resulting in a crisis of personal integrity. Deurzen (1998) however has argued that Laing did not account explicitly that "(…) the ontological insecurity at the core of schizophrenia is essentially there in all of us" (p.10) and understood ontological insecurity as pure existential anxiety, which is not limited to severely distressed people. Cooper (2009) made another significant critical remark on Laing's style by suggesting that his

approach to intersubjectivity advocated a restrictive perspective on the notion of self which he thought was located within rather than between the self and the world. Nevertheless, despite the aforesaid limitations, his contributions in inviting therapists who work with psychosis to question their assumptions about what they define as normal and abnormal remain unquestionably momentous and in line with Blankenburg's contributions, who is the last thinker presented in this section.

Blankenburg (1980) was critical of objectivistic psychopathology and suggested that sanity-insanity polarity was a dual possibility embedded in the fundamental ambiguities inherent in the human condition. He wrote extensively on the phenomenon of delusion from an intersubjective perspective and conceptualised it as an implicit possibility in our capacity for subjectivity within a shared intersubjective reality. Known for considering psychotic phenomena in the light of autism, he described how, in the state of autism and particularly the psychotic state, lived experience and self become doubtful. He understood psychotic self-doubt from an intersubjective perspective as a form of alienation and disengagement and claimed that intersubjective coexistence in psychosis is confusing and potentially threatening.

Even though some of the aforementioned thinkers attempted to provide assumptions about the aetiology of psychosis – mainly with Binswanger's a priori world designs and Laing's reference to dysfunctional social and family systems – they all remained faithful to the significance of subjective and intersubjective lived experience. However, while they described psychotic experiences from an E-P angle, they still retained a discourse that endorsed notions of pathology and normality in a similar way contemporary diagnostic systems do. Additionally, their conceptualisations of the notion of self in psychosis at times fail to recognise its intersubjective nature, a theme that will be unpacked in a later section.

2.2.3 Contemporary phenomenological approaches

Having already sketched the most significant early E-P contributions to the understanding of psychosis, this section will attempt an exploration of contemporary phenomenological approaches to psychosis and relevant phenomena. I will explain how these phenomenological approaches to psychopathology associate self-experience and other-experience distortions with the phenomena of delusions and hallucinations and how disturbances in affectivity, embodiment and temporality are considered to take form in the psychotic state. During the last two decades these approaches – mainly represented by researchers and clinicians from phenomenological psychiatry – have put the incomprehensibility of psychosis into doubt by understanding it as an outcome of abnormal neurobiology and a 'disorder' of self-awareness and self-experience (e.g. Parnas & Bovet, 2014; Stanghellini, 2009; Sass, 2000). These approaches have suggested that a disturbance of the basic sense of self – which is conceived at the pre-reflective level of selfhood – is the trait marker of psychotic vulnerability. In the following sections, emphasis will be placed upon the prominent psychotic phenomena and accompanied processes which these approaches seem to have identified, and how they have attempted to make sense of these phenomena.

The phenomenon of delusions

Delusions in mainstream psychiatry and clinical psychology are mostly understood in cognitive terms as 'false beliefs' (American Psychiatric Association, 2013) and are contrasted with 'normal' reality. Along these lines, complications in perception and distortions in the process of 'reality' testing are inextricably associated with delusions through a notion of reality often reduced to the physical realm (sensory experience believed to be the only valid source of knowledge about reality), which is mainly informed by a philosophy of *operationalism* and *logical positivism*. Instead, phenomenologically speaking, reality is not understood from a *physicalism* perspective but from a position where subjectivity and intersubjectivity are considered fundamental (Fuchs, 2015). Phenomenologically, we can therefore speak of a sense of

reality instead. As Parnas, Nordgaard & Varga (2010) have suggested: "(…) human reality is a reality of a lived world, i.e. a world always imbued with meaning, relevance, and objectivity co-constituted by our (inter)-subjectivity, with symbolic, social and cultural dimensions" (p.33). The phenomenological approach to delusions therefore provides the emphasis on the subjective and lived dimension of this phenomenon by questioning the very assumption that a delusion is, in essence, a false belief. Recent phenomenological researchers have strongly associated psychosis with disturbance of the basic sense of self which is thought to influence the generation and experience of delusions (e.g. Sass & Parnas, 2003; Sass, 1992; Parnas et al., 2005; Raballo & Maggini, 2005). These studies suggested that the basic sense of self is experienced in the *first-person perspective* where the experiencing subject and its thinking are united (Nelson et al., 2008; Parnas & Bovet, 2014). They suggested that several forms of delusional processes present difficulties in the first-person perspective with evident difficulties on the pre-reflective level of self-awareness. For example, in cases of *thought insertion* the person experiences that her thoughts belong to someone else. Similarly in *delusions of control*, the person truly believes that someone else causes her actions. A recent study by Raballo (2012) further supported the association between disturbances on the pre-reflective level of consciousness and delusional states. The researcher provided several vignettes of individuals expressing the experience of psychotic phenomena and demonstrated, through the analyses, the presented changes in the structures of subjectivity and intersubjectivity. More specifically the cases the researcher presented are described by alterations in the stream of consciousness, attunement to others and profound changes in the way people experience themselves, others and the world around them. He concluded that it is on the pre-reflective level of selfhood that the major disturbances of subjectivity take place in the case of psychosis. It is important to also note that similar remarks have been also concluded in empirical research conducted outside the phenomenological paradigm (e.g. Sierra, 2009).

The phenomenon of hallucinations

Alongside delusions, the phenomena of hallucinations – particularly the auditory – are among the most researched phenomena in psychosis (Naudin, Azorin, Guidicelli & Dassa, 1996). Hallucinations in psychiatry are usually conceptualised sensorily by being contrasted to 'normal' perception and are considered to occur when internal mental processes are misattributed to an external source (Bentall, 1993). However, the phenomenological approach follows a different line. For instance, Merleau-Ponty (1945/1962) rejected the assumption that hallucinations are false beliefs and instead suggested that a perceiving subject develops a strange relation to the external world through her hallucinatory state. In explaining his intersubjective understanding of hallucinations, Merleau-Ponty placed an emphasis on the function and meaningfulness of this phenomenon: "The patient's existence is displaced from its centre, being no longer enacted through dealings with a harsh resistant and intractable world which has no knowledge of us, but expending its substance in isolation, creating a fictitious setting for itself" (1945/1962, p. 342). Similarly, contemporary approaches associate the alterations of self-experiences, the experience of others and the world to the experience of hallucinations. Naudin, Azorin, Gidicelli and Dassa (1996) investigated auditory hallucinations from a phenomenological angle and concluded that these cannot be understood as disturbances in perception since the 'voices' the person hears are not isolated but rooted in a story from which they derive their meaning. These researchers suggested that the voices could not be understood as separate from the story in which they appear but rather develop in tandem with the story that describes them and their meaning. The authors have further suggested that the subjective hallucinated story is therefore constructed under the influence of the alterations of self and world experience.

The fundamental alterations of self-experience and world-experience have been systematically related to the generation of hallucinations from a plethora of earlier and later phenomenological studies alongside delusions (e.g. Binswanger, 1963/1993; Blankenburg, 1980; Sass, 1992; Sass & Parnas, 2003). These studies suggested that the phenomena of hallucinations exemplify an access to the structure

or breakdown of intersubjectivity. More specifically, these studies understand the hallucinator's difficulty in engaging with others through dialogue to be associated with the experience of internal voices, which challenge the essential intersubjective structure of experience that is oriented upon reference to a common world. Other studies explore the relationship voice hearers have developed with their voices. Knudson and Coyle (2002) for instance, employed an interpretative phenomenological analysis to explore how voice hearers made sense and attributed meaning to their voices. They indicated the conceptualisation of voices as dissociated aspects of the self and emphasised the dynamics of entering the client's meaning-making process and focused on the subjective understanding that clients adopted in relation to their voices. Similarly, Mawson et al. (2011) found that voice hearing appeared to influence their participants' sense-of-self and reflected their social relationships by personifying their voices.

Affectivity, embodiment and temporality

Alongside delusions and hallucinations, disturbances in affectivity, embodiment and temporality are considered fundamental in phenomenological thinking and are thought of as strongly interconnected, particularly in the case of psychosis (e.g. Mancini et al., 2014). For Merleau-Ponty (1945/1962) we can conceptualise subjectivity and the first-person perspective through embodiment. He particularly suggested that the intentionality of consciousness, our affectivity (how we are bodily engaged in situations) and temporality converge to produce subjectivity itself. Even though affect is a concept associated with complex and contradictory meanings within the psychological literature, for the purposes of this project it will be approached phenomenologically as a part of our embodied sensory experience and employed almost synonymously with emotions.

The affective states in psychosis are often associated with *negative symptoms*. The DSM associates negative symptoms in schizophrenia and other psychotic disorders (especially in the post-acute phases) with disturbances in affectivity through

diminished emotional expression (reductions in the expression of emotions in the face, eye contact, intonation of speech, and movements of the hand, head, and face) and avolition (decrease in motivated self-initiated purposeful activities) while it connects these behavioural symptoms mainly with neurocognitive deficits (American Psychiatric Association, 2013). However, studies have also shown that individuals with a diagnosis of psychosis often appear oversensitive to emotional stimuli and present intense affective reactions especially in paranoid forms of psychosis (e.g. Kring, 1999). Even though 'negative' symptoms have been associated with limited social function and difficulties in relating to others (Frith, 1994; Green, 1996), several contemporary studies have systematically provided evidence that many persons with a diagnosis of schizophrenia and other psychotic disorders can understand others' emotions in certain situations and monitor aspects of their own thoughts and feelings excessively (Sass, 1992; Stanghellini, 2004). Salvatore, Dimaggio and Lysaker (2007) suggested, in approaching negative symptoms from an intersubjective perspective: "These symptoms arise from impoverished goal-oriented action together with a chronic disadherence to intersubjective meanings" (p.159). In defining disadherence intersubjectively, the researchers asserted that several forms of negative symptoms of schizophrenia could be understood by the failure to express oneself, to participate in, or be attuned to the context of social interactions. They further stressed the importance of the changeable circumstances of the intersubjective context in the development of negative symptoms such as the difficulties in communicating emotions and understanding others' emotions and intentions and poverty of speech and action. These results suggest heterogeneity with respect to many characteristics of affective experience and expression in the psychotic state and have invited the attention of phenomenological approaches that have associated embodiment, intersubjectivity and temporality as central in conceptualising affectivity in psychosis. In approaching flat affect from a phenomenological perspective, Sass (2004) suggested that blunted affect is closely related to alterations in the experience of one's body and the world. More specifically he went on to explain how in the psychotic state, the normal fluidity and flow of affective experience and expression is disrupted by a fragmented and alienated sense of the lived body (e.g. the body or actions being controlled by a distant person or force) which causes a sense of distance between the person and the experience of her own emotions.

Contemporary approaches to psychosis have also paid significant attention to the phenomenon of disembodiment. As Irarrazaval (2015) stated, the term *embodiment* refers to the existential and experience-based dimension, which involves the embodied subject with regard to the intersubjective world. *Disembodiment* in psychosis presents itself as a disturbance in the experience of one's own body. The alienated sense of the body in the first-person perspective in psychosis has recently received considerable attention (e.g. Stanghellini, 2009; Fuchs & Schlimme, 2009). Stanghellini (2009) for instance presented evidence from transcripts in which people with psychosis express feeling detached from their own bodies and in other cases describe themselves as empty or hollow. Fuchs and Schlimme (2009) also presented evidence in which clients expressed an intense detachment from their own self and body through a loss of the sense of agency of their actions and movements, by accompanying the development of delusions of alien control. Clients often shared experiences in which they felt being somehow outside their body and observing it externally: "*I have a strange feeling that it's someone else's body*" (Parnas et al., 2005, p.252). Another client said, "*I sense my body, but it is far away, some other place*" (Parnas & Sass, 2001, p. 106). In her phenomenological investigation of embodiment and intersubjectivity for people with a diagnosis of schizophrenia during their first psychiatric hospitalisation, Irarrázaval (2015) concluded that intersubjectively speaking, major disturbances in the processes of synchronisation with others manifested. She employed in-depth interviews to gather qualitative data and recorded that the participants' bodies lost their central role and familiarity (body sensations, movements, perceptions etc.) with difficulties in getting involved with the world and others and resulting in various forms of body alienation and intersubjective difficulties, particularly in the second-person perspective.

As has been noted earlier, diverse experiences of disembodiment and disruptions in the flow of affective experience are phenomenologically associated with distortions in lived time or temporality. The fragmentation of the experience of self in time with the accompanied disturbances of the coherence of consciousness has often been associated with specific psychotic experiences in phenomenological literature. In presenting evidence from several case studies, Fuchs (2013) associated thought insertion and auditory hallucinations with 'inner time consciousness' and

described how this kind of disturbance manifested in a disintegration of intentional acts and a fragmentation of self-coherence that resulted in various forms of depersonalisation. A plethora of empirical studies has also presented evidence on how certain cognitive skills which are associated with lived time were found disturbed in psychosis, such as reduced attention span, disturbances in planning and synchronisation of speech (e.g. Manoach, 2003; Mishara, 2007). In explaining how embodiment and temporality are associated, Fuchs (2013) wrote: "Lived time may be regarded as a function of the lived body, opened up by its potentialities and capacities. The more we are engaged in our tasks, the more do we forget time as well as the body" (p. 80).

Summary

To summarise, the majority of contemporary phenomenological approaches to schizophrenia and psychosis have theorised that their primary feature is best conceived as a disturbance of self-experience, intersubjectivity, and disembodiment. They associate this disturbance with alterations of self-consciousness and self-experience at both the cognitive and the affective level, and in the perception of the body and in the values and beliefs about the world. The period during the formation of delusions and hallucinations is mainly perceived as a marker of vulnerability to psychosis and as a transformation of the structure of experiencing, with disturbances of the world-oriented and self-oriented experience (e.g. Fuchs, 2010). These interconnected phenomena are thought of as inherent to the psychotic state and have been organised into a semi-structured interview format titled the "Examination of Anomalous Self-Experience" (EASE; Parnas et al., 2005), which is widely referenced in current phenomenological approaches to psychosis and schizophrenia. Further attention and a critical appraisal of this construct will be attempted in the following section.

2.2.4 A critical review of contemporary phenomenological approaches

Having already sketched the major contemporary phenomenological approaches to psychosis, this chapter aims to provide a critical review of these approaches, based on an E-P intersubjective perspective which in all its forms rejects the subject-object dualism, which is central in positivism and abandons the generalised once-and-for-all knowledge (Gadamer, 1960/1996). Before commencing, it is important to note that the majority of these approaches have been developed within psychiatry and therefore complete abnegation of the engagement with basic psychiatric discourses (e.g. pathology, anomaly, symptoms) would be almost impossible. Despite the differentiation which these approaches have demonstrated from mainstream psychiatry in their efforts to endorse phenomenological, hermeneutic and existential concepts which is deeply encouraging, it seems that matters of professional identity might be causing a conflict in their efforts to fully integrate the E-P model. For example, while they have highlighted the significance of investigating beyond symptomatic descriptions by suggesting a richer phenomenological approach to the understanding of disturbed experience, they do not escape from mainstream psychiatry's operationalist deadlocks and employ a language which retains an attitude that incorporates pathology as a foundation which is taken for granted. These approaches can also be considered anti-phenomenological and reductionistic to some extent since they have suggested that the phenomenon of self-disorder is developed before the onset of psychosis. They therefore clearly endorse principles of prediction (e.g. Edwards & McGorry, 2002; Nelson et al., 2008), which are incompatible with the E-P paradigm that they have openly assumed adopting. Generally speaking, from an E-P perspective we cannot assume that psychological well-being can be predicted by or reduced to the basis of particular symptoms.

Parnas and his colleagues (e.g. Sass & Parnas, 2003; Sass, 1992; Parnas et al., 2005; Raballo & Maggini, 2005) have defined the pre-reflective, basic level of self-experience as the subjective experience of agency, coherence, unity, temporal identity and demarcation, accompanied by a pre-reflective sense of engagement in the world. As has been explored earlier, this phenomenological model considers the changes of this pre-reflective, basic sense of self at the core of psychosis. However, it calls

attention to some conceptual issues related to the multiple notions of self in the literature. Moreover, even though Sass and Pienkos (2013) have also suggested that the person's pre-reflective disturbance is the principal cause for failing to meaningfully engage therapeutically, I consider that they have failed to take into consideration what might be happening in the intersubjective space 'between' client and therapist so long as there is no reference to the therapist's experience, limitations, and vulnerability.

From an E-P perspective, these approaches appear problematic in terms of employing pathological conceptions of the self, accompanied by diagnostic processes and procedures. The terms *mental illness*, *symptoms, schizophrenia*, and *anomalies* are often employed with a manner of certainty that seems to objectify mental conditions and experience. Regardless of the commitments made to the phenomenological thinking, these approaches employ a language that provides an unrelenting investment in the medical model and in psychiatric discourse. These discourses are not thoroughly reflected and do not have adequate phenomenological bracketing, and therefore they carry a great potential to subvert the phenomenological thinking they are trying to introduce. Instead, the E-P perspective suggests careful attention when referring to human conditions in pathological terms, especially in the case of making generalisations. The idea that a genuine science of human experience requires its own concepts and methods that cannot rely on imitating the sciences of nature forms a central tenet of the E-P movement (e.g. Deurzen, 2002). Additionally, even though some instruments have been developed (EASE, Parnas et al., 2005) for assessing self-disorders in the area of diagnosing an early psychosis, and are a great example of introducing phenomenological thinking into areas not taken into account within the criteriological manuals of diagnostic systems (self and body awareness, agency and identity, time flow, understanding others, etc.), they need to deal with this issue with greater sensitivity. This is especially true considering the possibility of maintaining the stigma of diagnosis. Moreover, this particular diagnostic inclination contradicts the very phenomenological philosophy that is supposed to underlie it.

Additionally, Parnas' and his colleagues' model of disturbances on the pre-reflective, basic level of self-experience seems problematic from an intersubjective

perspective in that it separates the subjective perception from its intersubjective context. For example, they seem to describe a core pre-reflective self as having a universal quality without reference to the possibility of lacking generalizability outside Western cultural contexts. Therefore, from an intersubjective perspective that is sensitive to cultural differences and context, it fails to consider cultural variation in the development of a sense of self. Moreover, the concept of a stable, basic sense of selfhood as described by Parnas and colleagues (2005) can be challenged from an intersubjective perspective which advocates the continuous and dynamic revision a sense of self undergoes. The idea of a stable sense of self seems to be universally rejected these days even outside phenomenological literature with many different schools of thought converging on the idea of multiple selves or the socially constructed self, from *social constructionist* approaches (e.g. Gergen, 2011), to *developmental neuro-cognitive* approaches (e.g. Hood, 2012). What remains unclear is whether the conceptualisation of the core self-disorder in psychosis is open to the possibility of psychotherapy. The question of how psychotherapy can assist someone with basic disturbances of self-experience has not been given enough consideration. The risk of cultivating a new therapeutic pessimism should be carefully considered at a time when a direction toward recovery is being advocated for people diagnosed with psychosis. Moreover, their phenomenological attitude fails to take into consideration the significance of intersubjectivity and relationality in the emergence of psychosis and at times seems stagnated in a Husserlian transcendental phenomenology of consciousness, which, instead of moving toward the phenomenology of existence, is more reductive than hermeneutic. Their emphasis on the first-person, subject-oriented approach focuses mainly on the person's conscious experience and explores its basic and often implicit structures (Fuchs, 2010) while it neglects the intersubjective, second-person approach which will be presented later as an alternative.

To conclude, the majority of the above-mentioned approaches have developed an exciting phenomenological account of psychosis having been disregarded for a long time in the literature. However, they encase their conceptualisation in an objectifying psychiatric diagnostic language that contradicts this very conceptualisation, while they engage excessively with the first level of pre-reflective self-awareness and overlook the significance of intersubjective, second level

reflective self-consciousness and other-awareness. In what follows, an eclectic E-P understanding of intersubjectivity is attempted, which will be linked with the implications for the psychotherapy for psychosis and particularly the experiences of psychotherapists.

2.3 A PHENOMENOLOGICAL APPROACH TO INTERSUBJECTIVITY

2.3.1 Overview

A phenomenological exploration of intersubjectivity makes up a critical section of this thesis as has already been pointed out, and the contributions of Merleau-Ponty (1945/1962, 1968), Binswanger (1963/1993; Frie, 1997; Lanzoni, 2003; Koehler, 2004), Buber (1921/1996, 1947/2006, 1992), and Scheler (1912/1961; 1912/1970), will mainly inform the form of intersubjectivity which this project endorses. I consider that an amalgamation of the individual influence each thinker has provided for the concept of intersubjectivity contributes towards a dynamic conceptualisation of psychotic experience and the potentials of psychotherapeutic praxis. The criterion for placing particular emphasis on these thinkers was based on their conceptualisation of intersubjectivity as a primary state, which evaluates any kind of experience as intervolved within our being-in-the-world and is perceived as an important alternative to the individualism of certain phenomenological approaches, which perceive self-consciousness as non-relational (e.g. Sartre, 1943/1956). The commended intersubjective approaches refer to the problem of determining the relationship between self and other, how self gains knowledge about others and how others affect one's own self-experience and other-experience. Moreover, they place a significant emphasis on the second-person perspective, which is significant for the conceptualisation of psychosis from an intersubjective point of view, which has been neglected in the contemporary phenomenological literature. As Gallagher (2001) stated, "In second-person interactions, the mind of the other is not merely hidden or private, but is given and manifest in the other person's embodied comportment" (p.203). But before explaining the rationale for excluding other E-P thinkers who

have significantly contributed towards the conceptualisation of intersubjectivity (e.g. Husserl, 1925/1977; Sartre, 1943/1956; Heidegger, 1926/2001), I will firstly make some clarifications in terms of how the concept of intersubjectivity is employed in the phenomenological literature. Even though different phenomenological approaches deal with the concept of intersubjectivity in a range of ways, what seems to connect all existing approaches are their objection towards a strictly solipsistic account of the self and an assumption of a shared world. More specifically, Crossley (1996) made a clear distinction between egological/transcendental (e.g. Husserl, Sartre) and radical intersubjectivity (e.g. Buber). I consider it important to briefly unpack and distinguish between the main forms of intersubjectivity as they appear in the phenomenological literature in order to explain the version of intersubjectivity I have endorsed in this project, which is compatible with the chosen methodology (IPA) and therefore my epistemological and ontological assumptions.

Egological intersubjectivity has its origins in Husserlian transcendentalism and "(…) involves an empathic intentionality which experiences otherness by way of an imaginative transposition of self into the position of the other" (Crossley, 1996, p.23). Phenomenologists who support an egological or a Husserlian view of intersubjectivity understand the self as the 'I' which stands at the back of conscious experience and accounts for the unity and continuity of its conscious experiences. Husserl's project clearly suggested that a relationship between subjects is not something given and that the person needs to establish a relationship with the other in order to overcome the isolation of its 'I'. For Husserl, the subject (or self-consciousness) is not enmeshed in the world and always maintains its autonomy and agency within an intersubjective world. Husserl assumed that making sense and empathising with others requires an imaginative analogical procedure (understanding the Other's experience through a consideration of one's own experiences), which mainly consists of a cognitive conceptualisation. The other in a Husserlian conceptualisation is, therefore, an alter-ego, that is very similar to me on an embodied, cognitive and affective level.

On the contrary, radical intersubjectivity "(...) involves a lack of self-awareness and a communicative openness towards the other, which is unconditional. Self engages with other in this modality but has no experience of them as such" (Crossley, 1996, p.23). Phenomenological approaches that maintain a radical view of intersubjectivity assume the conception of the autonomous 'I' as pointless, because the 'I' only appears in consciousness upon reflection. While Husserl's philosophy emphasised the individual's relationship with oneself and goes from there to Others, Heidegger commences with our relationships with others and then expands his exploration of how to regain our relationship with our selves (Thompson, 2005). His conception of *Dasein* as *Mitsein* (being-in-the-world-with-other-people) suggested that we are enmeshed in the world with Others and one cannot extricate oneself from this world: "The world of Dasein is a with-world (*Mitwelt*). Being-in is Being-with-Others" (Heidegger, 1926/2001, p.155). The Heideggerian ontological perspective assumes that people are already pre-reflexively empathic to others because they are already ontologically being-with Others and therefore not concerned with the Husserlian emphasis on agency and autonomy: "It could be that the 'who' of everyday Dasein just is not the 'I myself'." (Heidegger, 1926/2001, p.150). In the following section I briefly explain why Heidegger's, Sartre's, and Husserl's versions of intersubjectivity are not entirely in line with this project's epistemological and ontological position that is situated between a radical and an egological understanding of intersubjectivity and in line with Crossley's (1996, p.71) contention that:

> *Human subjectivity and intersubjectivity, as Buber argues, swing between this egological mode of intersubjectivity and the more radical mode. Sometimes we are deeply engrossed with others, too engaged to be aware of either ourselves or of them. At other times, and rapidly, we can become sharply aware of both, constituing them as reflective and reflexive aspects of experience.*

2.3.2 A critical review of Heidegger, Sartre and Husserl

Husserl's contribution to the concept of intersubjectivity was tremendous as he was the philosopher who first introduced the concept itself (Zahavi, 1996) and considered it to be an essential quality of human existence. He approached intersubjectivity not as an outcome of interaction but as a condition for its possibility (Duranti, 2010) – therefore making a clear distinction between empathy and intersubjectivity – and insisted that throughout our existence in the world we are constantly confronted with intersubjective meaning. However, as Sartre (1943/1956) has suggested, Husserl failed to find a way to reconcile the intersubjective quality of human experience with its subjective foundation because he was over-involved with the analysis of the transcendental dimension of intersubjectivity, while his commitment to transcendental idealism has led to accusations of endorsing a solipsistic approach. According to Duranti (2010), Husserl's conceptualisation of intersubjectivity carries numerous unresolved issues, which are compounded by his inclination "(…) to return again and again to the epistemological and ontological foundations of his philosophy while providing very few exemplifications of what he had in mind" (p. 2). With his overemphasis on the first-person perspective and the intentionality of individual consciousness, he neglected to pay attention to the second-person perspective and the implication of otherness in the intersubjective quality of experience. Along these lines, Zahavi (1996) elucidated that: "The main aim of his reflections was the formulation of a theory of transcendental intersubjectivity and not a detailed examination of the concrete sociality or the specific I-Thou relation" (p. 229). Instead, as Ware (2006) commented, in the Husserlian tradition the subject is defined as a self-enclosed transcendental ego, which therefore leads to the problem of solipsism (the subject is a hermetically sealed individual) since authentically encountering otherness becomes impossible.

Moving on to Heidegger's ontological project on intersubjectivity, it seems to manifest in his conception of Dasein as Mitsein or being-with (Heidegger, 1926/2001). Even though he understood intersubjectivity as an essential and a priori determination of Dasein, Heidegger overlooked radical otherness and how intersubjectivity is manifested and experienced through concrete encounters with

others. He was therefore partly unsuccessful in capturing our unique and essential relation to others. As Ware (2006) has commented, Heidegger's departure from Cartesian egology "(...) is deniably radical, yet I do not believe we deepen our understanding of intersubjectivity by replacing the notion of a solitary ego with a social pre-ego" (p. 503). Sartre, on the other hand, stressed the importance of recognising the impact of radical otherness but did not understand intersubjectivity as an essential and a priori determination of existence. Zahavi (2001) commented that "Compared to Heidegger's account, Sartre's treatment of intersubjectivity emphasises the transcendent, ineffable and elusive character of the other, and rejects any attempt to bridge or downplay the difference between self and other" (p. 158). Sartre's claim, that concrete encounter with the other is experienced as alienation, disregarded the common intersubjective platform upon which we are all situated and that any conflict would be inconceivable if there were not previously a communal ground and a peaceful coexistence (Zahavi, 2002). Sartre (1943/1956) assumed an 'ontological separation' between self and other in his conceptualisation of being-for-itself and suggested that "I am incapable of apprehending for myself the self which I am for the Other, just as I am incapable of apprehending on the basis of the Other-as-object which appears to me, what the Other is for himself" (p. 327). He therefore understood intersubjective relation as pure conflict devoid from the possibility of being-with and his understanding of otherness equated with oppression.

The abovementioned approaches to intersubjectivity and otherness have been significantly influential within the E-P paradigm. However, the particular limitations discussed above illustrate their unsuitability for the purposes of this project in exploring intersubjectivity in psychosis, and particularly in the psychotherapy for psychosis. In the following section, I turn towards the exploration of the radical approaches to intersubjectivity of Merleau-Ponty, Binswanger, and Buber, which I consider provide a better understanding of the phenomenon of psychosis and, more importantly, the experiences of therapists working with psychosis.

2.3.3 The consideration of Merleau-Ponty, Binswanger, Buber and Scheler

Maurice Merleau-Ponty

Merleau-Ponty's (1945/1962, 1968) project on intersubjectivity was mainly focused on his conceptualisation of *intercorporeality*, *perceptual consciousness,* and *self-alterity*. His notion of the intercorporeal in relating to others was fundamental for establishing that intersubjectivity is a concrete relationship and suggests that our existence in relation to others is something corporeal (Csordas, 2008). Merleau-Ponty was not interested in the body as an object in its biological terms but in the lived body as a subject, as a being-in-the-world, as open and reflexive, which interacts dynamically with the world and others in a reciprocal way. His explanation of incorporeal intersubjectivity was investigated through the role of perception, speech, gesture, and emotion. As Diamond (1966) has suggested in light of Merleau-Ponty's project on intersubjectivity, emotional bonds among people are possible because we live primarily in the other's gestures and responses. This seems relevant to the psychological and psychotherapeutic literature on emotion regulation and embodiment (e.g. Schore, 2003). This conceptualisation of the body condemns the Husserlian view of self-enclosed viewpoints and suggests an intersubjective constitution of the body and its consciousness. Merleau-Ponty's concept of intercorporeality emphasised the social nature of the body and the bodily nature of social relationships. Along these lines, Weiss (1999) highlighted that "The experience of being embodied is never a private affair, but is always mediated by our continual interactions with other human and nonhuman bodies" (p. 5).

Merleau-Ponty's extended project on perception and intentionality (e.g. (1945/1962), included all perceptual processes and their interconnections. It asserted that we are constantly in the world of perception, and consciousness is, therefore, a perceptual consciousness. Crossley (1996) commenting on Merleau-Ponty's approach to perception asserted that it is an "(…) originary process, rooted in the dialectical relationship of the organism and its environment, which gives birth to both the subject and the object of perception" (p.27). Perception in this sense is not only an experience of objects and subjects but also a meaningful association of them. This "(…)

perceptual consciousness or perceptual field forms in the space between perceiver and perceived by means of the active engagement of the two" (Crossley, 1996, p.29). This intersubjective understanding suggests that perceptions and their intentionality are not located inside the perceiver but outside of her, opening her into that world and connecting her to the world and others. Likewise, emotions are dialogically established and not strictly inner states but intersubjectively definable states, which become manifested in the way we act, and this clearly questions the notion of 'inner' life and 'outer' reality prominent in the mainstream understanding of psychosis. Crossley (1996) further commented on this and suggested that not only mental events are visible from the outside as from within but also "…it follows from this that we become aware of our own mental states in the same way that we become aware of the mental events of others. Thus, our mental states are, in principle, always intersubjectively available by way of our performances" (p. 34). Merleau-Ponty advocated that when exploring perception we should be interested in a person's familiarity with the lived world and how the perception of objects consisting of that intersubjective world depends on a sense of being affected by and belonging to it.

Merleau-Ponty's conceptualisation of otherness challenged the solipsistic notion of private perceptual worlds. Furthermore, it went a step further to suggest that subjectivity and therefore its consciousness is defined not only as an opening onto alterity of the other but also as an alterity of the self. This is, according to Zahavi (2001), the most significant characteristic of Merleau-Ponty's conceptualisation of intersubjectivity. In other words, before a subject is open and available to the other, she is already an Other to herself. As Zahavi (2001) articulated: "I can only encounter the other if I am beyond myself from the very beginning; thus I can only experience the other if I am already a possible other in relation to myself, and could always appear to myself as an Other" (p. 159). In a similar fashion, Levinas (1961/1969), in his conception of otherness, claimed that in every encounter with an Other there will always be an element of the other that will be ungraspable. Expecting a total understanding of the other and therefore, a total understanding of self is problematic as this objectifies the other's autonomy and misses something of the other's humanity. Merleau-Ponty clearly claimed that self-experience must enclose an aspect of otherness; otherwise, intersubjectivity would not be possible. He assumed that

exteriority is the common denominator between self-awareness and awareness of others (Merleau-Ponty, 1945/1962, p. 354):

> *In the experience of dialogue, there is constituted between the other person and myself a common ground; my thoughts and his are interwoven into a single fabric, my words and those of my interlocutor are called forth by the state of the discussion, and they are inserted into a shared operation of which neither of us is the creator.*

In other words, in order to be able to experience my own subjectivity on a pre-reflective level, this very experience must enclose an anticipation of the other. Intersubjectivity is possible because the manner through which I experience my own subjectivity predicts the way I meaningfully experience the other because the other emerges on the horizon of my self-experience. From this perspective, Merleau-Ponty understood intersubjectivity as the principal union of perception with which I am familiar with others as being analogous to myself (identifying with the body of the other, her gestures, actions, emotions and so on).

Ludwig Binswanger

As has been already noted in the section of early E-P approaches to psychosis, Binswanger was a pioneer in establishing a non-reductionistic approach to human suffering and dealt with the issue of intersubjectivity in therapeutic work with psychosis. In this section, I will deal with his contributions to intersubjectivity, which are a significant alternative to the individualism of certain philosophical, psychiatric and psychoanalytical thought. Lanzoni (2003) proposed that Binswanger's understanding of intersubjectivity in human distress contributed towards the emergence of the anti-psychiatric movement. He suggested that a subject emerges because of its relation to the other and therefore can be understood in its *inter-human* context. He was greatly influenced by Buber's philosophy and his conception of the *I-Thou* relationship, where *communal love* and *we-ness* are considered as the only way

through which the self is revealed. Binswanger (as cited in Frie, 1997, p. 134) considered that,

> *The human being is only "human" in speaking-with-one-another, in the communication of I and Thou as we, on the basis of a shared linguistic world or a shared linguistic world-design. Language is not a mere medium of exchange, but a being-with-one-another in a world that makes understanding possible.*

Binswanger spoke of the constitutive importance of duality, which he understood as an ontological unity that locates the person within a framework of meaning. Similarly to Heidegger, he also supported that the human being continuously changes in a shared and articulated world and that human development takes place only through dialogue with the other. Heidegger's concept of being-in-the-world allowed Binswanger to develop a philosophical approach to psychiatry and psychopathology which put at its centre the pursuit of understanding of how a person inhabits a particular context and how she discovers meaning or not within the limits of its context. Along these lines, he considered that the main roles of psychopathology was to explore alterations in lived experience, how a person structures her world, and how she relates to her environment and others. However, he rejected Heidegger's position that authenticity and self-realisation can be achieved in isolation. Moreover, he considered that Heidegger failed to appreciate the importance of the dialogical I-Thou for the attainment of authentic selfhood, with his fundamental ontology failing to value intersubjective relations. Binswanger instead emphasised that self-realisation could only be achieved through reciprocity in relation, which he suggested is built upon a dynamic balance between separateness and relatedness. The separateness involves the acknowledgement of the otherness, the distinctive alterity of the other and the experience of authentic selfhood. As Frie (1997, p.106) has noted,

> *Binswanger insists that intersubjective reciprocity must always be predicated upon acknowledgment of the other's alterity. Without affirmation of difference, the other will become dominated and dependent, or be reduced to a mere third person, one who stands over and against*

me. By elucidating the interrelation of separateness and togetherness, Binswanger provides a framework within which to understand the structure and importance of reciprocity in a love relation.

Martin Buber

Given the often described intense alienation, despair and intense self-reflection people with psychosis experience, Buber's theory of intersubjectivity and dialogical theory are particularly meaningful because he understood that human experience, suffering, and reflection are essentially intersubjective processes. The concepts that Buber has introduced that are considered as relevant for this project are the *I–Thou* and *I–It* modes of relating, the *space between*, and *confirmation* (Buber 1947/2006, 1921/1996). According to Buber, the two available responses people have in encountering otherness are to authentically relate with the other as a subject (the I-Thou encounter) or as an object (the I-It encounter). He suggested that both responses are vital for the emergence of selfhood and the negotiation of otherness, however, he placed significant emphasis on the I-Thou mode of relating. Similarly to Merleau-Ponty, he understood subjectivity as essentially directed towards alterity (Merleau-Ponty would say that it is intentional and corporeal), which can take up either the form of I-It or I-Thou. He suggested that when engaged in I-Thou, mutuality, meaning and co-creation are possible while he attached to his I-Thou conceptualisation not only an ontic but an ontological status which he saw evident in humans' intrinsic capacity to know and be known. The highlighted ontological primacy of relation suggested that mutuality in the I-Thou relation is manifested in the *immediacy* of the encounter. For Buber human existence is not a self-contained phenomenon but something that stretches beyond its own being. This is evident in his proposition that the I-Thou is a primary relationship, which enables the emergence of the self as a being-in-the-world, contingent upon grasping the being-in-the-world of another self.

Buber's ontological primacy of his project rested mostly on his conceptualisation of the space between I-and-Thou. He suggested that the unity

between self and other rests on the reality of the division among them. This space in-between can never be fully understood, nevertheless it is the basis and condition for the experience of mutuality: “Spirit is not in the I but between I and You” (Buber, 1921/1996, p. 89). Intersubjectivity in Buberian terms can, therefore, be understood as the space between or the *inter-human* as Buber called it; an irreducible and primordial space. The space between the two embodied subjectivities calls for a mutual understanding. Even though, at first glance, someone might assume that Buber’s intersubjectivity exclusively describes aspects of concrete encounter and interaction in the second personal perspective (perspective-taking, putting oneself in another’s shoes, etc.) his understanding of intersubjectivity was deeply embedded within a transcendental relation and it is conceptually very close to the *primary intersubjectivity* and *intercorporeality* of Merleau-Ponty. It is primary exactly because it allows the subject to identify her own consciousness in the process of identifying the other’s consciousness. Crossley (1996, p.17) describes this clearly:

> *Only through the mediation of the consciousness of the other can consciousness turn back upon itself and identify itself: Consciousness only becomes aware of itself when and to the extent that it identifies the existence of other consciousnesses. Self-consciousness is an intersubjective phenomenon in this sense, achievable only through mutual recognition between consciousnesses.*

Essential to Buber's notion of the between was the conception that subjectivity requires *confirmation* by the other (Buber, 1992, p. 5):

> *Man wishes to be confirmed, and wishes to have a presence in the being of the other. Sent forth from the natural domain of species into the hazard of the solitary category, surrounded by the air of a chaos which came into being with him, secretly and bashfully he watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that the heavenly bread of self-being is passed.*

Buber, therefore, suggested that confirmation of the self is not equal with a mere acceptance of the self or the self having his existence confirmed by the Other, but for the self to also be established as an Other, for self and Other. This conception is similar to Binswanger's understanding of mutuality as the result of an interchange between separateness and relatedness. It is important to note that for Buber, confirmation of the other does not consist of a smooth process and can also take the shape of confrontation. He asserted that we could confirm something in the other that is in conflict with other aspects of that other and this kind of confirmation can underline distress within self and other.

Max Scheler

Along similar lines with Merleau-Ponty, the phenomenologist Max Scheler's project on intersubjectivity approached human relations as essentially connective and meaningful while it condemned the Husserlian outlook of a self-enclosed consciousness, and instead suggested an intersubjective constitution of the body and its consciousness (Scheler, 1912/1961; 1912/1970). He proposed that the nature of our self-knowledge is not purely mental but constituted between and within other people, therefore emphasising the intersubjective constitution of our self-experience. Similarly to Merleau-Ponty, he also emphasised the significance of the interaction between mind and body and proposed that our experiences of self, others and the world are not deeply hidden into our minds and isolated from others but instead are manifested and expressed in bodily gestures and actions. Scheler also emphasised the role of intuition and inter-affective exchanges for gaining access to other's experiences, which he asserted as closely related to our felt sense and emotional states and therefore totally relevant to the field of psychotherapy. Moreover, his proposition that knowledge of the other is tightly associated with self-experience and that boundaries of the self are defined by how integrated a person feels in her community (Scheler, 1912/1970), seems greatly related to the conceptualisation of interrelational complications in the psychotic state of mind, pointing as it does towards the dynamic association between an impoverished sense of self in psychosis and intersubjective breakdowns.

2.3.4 Synopsis and implications

This section attempts to amalgamate the intersubjective approaches of Merleau-Ponty, Binswanger, Buber, and Scheler, and based on them suggest possible implications to the comprehensibility of psychosis. These approaches suggest that we are ontically and ontologically inseparable from the world and others, understand intersubjectivity as an existential potentiality, an a priori imperative and a mode of being which conceptualises the other as a permeable embodied subject.

From a Sartrean or a Heideggerian perspective, these approaches might be criticised as suggesting an exclusively ontic or anthropological conceptualisation of intersubjectivity, which focuses mainly on interactional processes. However, based on a Merleau-Pontian, Binswangerian, Buberian and Schelerian vantage point, I advocate an exploration of intersubjective engagement that has an ontological status and endorses an approach that explains the nature of consciousness itself even in its pre-reflective sense. As has been already explored, Merleau-Ponty (1968) clearly claimed that immediate or pre-reflective embodied self-awareness is intersubjective in nature. The intersubjective approaches explored value the conscious and lived personal experience while they consider human existence as fundamentally and inextricably immersed in its world. Moreover, they move away from the Husserlian emphasis on agency and its cognitive and conscious processes and are more focused on an embodied, practical and concrete involvement with the world. I suggest that approaches that employ the paradigm of impenetrable, radical and extreme otherness to intersubjectivity (e.g. Sartre's) are insensitive to the possibility of mutual recognition, especially in the case of psychosis. I also consider this one-sided conceptual emphasis of fundamental otherness to be problematic, especially in its application to the therapeutic situation as shall be later explained. Their lack of attention towards the process of being perceived and experienced (second-person perspective) and their overemphasis on the process of perceiving (first-person perspective) makes them inadequate to approach human distress intersubjectively, as the state occurring in the Buberian and Binswangerian *betweenness* of the person and the world.

Although the connection between psychosis and an intersubjective deficit is well documented, this hypothesis seems problematic to a certain extent. How can we apply this assumption in the case of a shared psychosis, such as in *folie a deux* and *folie a plusieurs*? In light of these cases when two or more people are experiencing the same psychotic experiences, someone might assume that these people are not living in isolated private worlds but instead are intersubjectively and meaningfully connected through these psychotic experiences. Moreover, in the cases of hallucinations, as is often reported in the literature (e.g. Kobayashi et al., 2004), people respond to their hallucinatory voices and hold meaningful conversations with them. Someone might rightly suggest that they are not trapped in their own private worlds but instead caught in an intersubjective world with their own hallucinatory characters and become part of an intersubjective world different from that shared by the not-psychotic community (Maung, 2012). What also seems to be ignored is that delusions are often presented as fundamentally intersubjective phenomena, both in form and content and manifest themselves in an intersubjective situation by demonstrating a persistent orientation to others by whom the person feels persecuted or manipulated.

Additionally, the person with psychosis is 'accused' of embodying an impenetrable otherness. Jaspers (1949/1963) for example insisted that the alteration of self-experience a person with psychosis goes through is so extreme which makes it incomprehensible, and the possibility of empathising and understanding becomes almost impossible due to the lack of meaning. Yet, intersubjectively speaking, we cannot speak of a lack of meaning as located within the self and therefore cannot meaningfully understand the self and her suffering in isolation from its context. From a Merleau-Pontian perspective meaning or its lack emerges because is found (or not) in the cultural and historical space in which the embodied subject is situated. In exploring the pre-reflective structuring of meaning in the subject's intentionality, Merleau-Ponty asserted that it is bodily and socio-cultural in nature and implied that pre-reflective consciousness and its intentionality are intersubjectively constituted and maintained. However, existentially and intersubjectively speaking we are not only defined by our socio-cultural embeddedness. The project of becoming a self also calls for an integration of the 'anonymous' being or being an anonymous anybody (Keller,

2008). From a Merleau-Pontian and Schelerian viewpoints, the embodied subject is not therefore ontologically separated from others, yet is an anonymous existence, with its immediate intentionality characterised by an ambiguous structuring of meaning, which occurs in perception and expression pre-reflexively (Merleau-Pontly, 1945/1962). This 'anonymity', which might generate a sense of alienation in the person, is something universal and can be explored in relation to the experience of loneliness and separateness from the world and from others. Alienation is also contained in the Buberian *betweenness* as a collective phenomenon and the experience of separateness is transcended without negation of otherness. It accepts both otherness and mutuality as valid and recognised in the space between self and other, with the philosophically isolated 'I' and 'you' being replaced with a 'between'. However, from a Buberian viewpoint, this process of oscillating between self and other, mutuality and separateness remains a fragile one. Along these lines, Rosfort and Stanghellini (2014, p.383) have argued that

> *The fragile character of human experience stems from a basic dialectical interplay of selfhood and otherness at the heart of our identity as human persons. To be a person is to live with the intimate alienation that we experience in our emotional life. Our emotions are intimate in the sense that they are our emotions, and they are alienating in the sense that at work in those self-same emotions is an otherness that constantly disturbs our sense of being an autonomous self.*

These particular considerations generate several reflections within an intersubjective conceptualisation of psychosis and its psychotherapy. Someone might rightly ask: What does a person's difficulty in relating to a person with psychosis signify about her own relation to self-alterity? How is that person's self-experience affected in enclosing aspects of psychotic otherness? What might the difficulty in meaningfully experiencing the other with psychosis say about the possible difficulty in allowing the other with psychosis to emerge on the horizon of self-experience? What are the dynamics of a person's oscillations between mutuality and separateness in encountering the person with psychosis? Moreover, how does the alienated experience of the person with psychosis affect the therapist's own ambiguous

structuring of meaning pre-reflexively? I believe that these are fundamental considerations if we are to understand psychosis intersubjectively and promote recovery through the praxis of psychotherapy. However, they are hugely neglected or not adequately considered in the E-P literature on the conceptualisation and psychotherapy of psychosis let alone the broader literature. Intersubjectively speaking, the provision of any kind of psychological or psychotherapeutic input for the case of psychosis (and any other manifestation of human distress), must therefore irrefutably embrace a detailed consideration of the professional's subjective and intersubjective experiences, which appears lacking in the literature. The literature seems to bursts with publications which document the experiences of people receiving services, and their interpretations based on the theoretical model by which the data are explored but lack a detailed analysis of the professional's involvement and her contribution to the process of assessment, therapy, etc. To my own understanding, this is no lesser intersubjective deficit than the one the person with psychosis is 'accused' of.

A holistic approach to intersubjectivity must, therefore, include a second-person intersubjective methodology and epistemology where it remains necessary to explore the experiential perspectives of self and other and to consider the phenomenon of the subject reflecting upon its own subjectivity in the I-Thou encounter. The second-person approach can provide the conditions for the Buberian confirmation and suggest a dialectical process of shared meaning with its goal directed towards opening those engaged in it to new worlds of meaning through the exploration of what is shared. Since our experience in the world with others is based upon co-construction of meaning, the second-person intersubjective encounter suggests that through the Buberian notion of mutual interaction in the space between, co-construction of meaning is made possible. A second-person perspective in the case of the psychotherapy of psychosis appears, therefore, fundamental. The therapist's understanding of the client's experience must, therefore, remain in the second-person, which embraces the sense that the other's experience belongs to them, whatever is experienced and is felt by them in a way that is different from the therapist's experience of it. This process invites the process of recovering understandability, which can be a key aspect in overcoming the client's sense of alienation. Similarly,

Gallagher (2011) coming from a dialogical perspective suggested that a second-person perspective opens up potential ways of approaching autonomy in a new light. This kind of potential provides the grounds for reflection on the therapist's intersubjective involvements.

Concluding, the second-person approach to intersubjectivity implies that it remains necessary to explore the experiential perspectives of both parties in the relation by negotiating the shared focus of attention and trying to make sense of the intentionality in both parts. Intersubjectively conceived, there is a circular interdependence between the way the person with psychosis experiences the therapist and the way she experiences herself and the other way around. Therefore, the co-construction of intersubjectively shared narratives implies that the detailed exploration of a person's subjective experience of self and other (the person with psychosis) allows a better understanding of the person's relating to the world and others with tremendous implications for psychotherapy. In the following section that deals explicitly with the psychotherapy of psychosis, I focus on the form and praxis of intersubjectively informed psychotherapies for psychosis and the related psychotherapists' experiences through an exploration of relevant literature.

2.4 PSYCHOTHERAPY FOR PSYCHOSIS

2.4.1 A brief history of the psychotherapy for psychosis

Before the introduction of psychological and psychotherapeutic services for people with severe psychological distress, their 'management' in asylums consisted of cruel actions and compulsory separation from other people and their communities (Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013). The reformation of asylums and the development and introduction of 'moral treatment' gradually lead to the introduction of more humane practices, which however did not include individualised care (Scull, 1981). The development of psychoanalysis was another major shift in terms of treating people in distress with dignity and respect, and although Freud

advocated that psychosis was not a condition which psychoanalysis could treat (Freud, 1924/1961), by the 1940s several psychoanalysts illustrated successful case studies of people with psychosis (e.g. Fromm-Reichmann, 1954; Sullivan, 1962; Searles, 1965). However, despite the enthusiasm, this major shift was brought about by anecdotal evidence as the literature on the psychoanalysis of psychosis failed to a certain extent to provide the appropriate evidence for its efficacy. This shift was gradually followed by an emphasis on medication, rehabilitation and skill acquisition and the anti-psychiatric movement gradually evolved in response to these changes, especially as a response to the application of medication being the major form of treatment (Scull, 1981). Even though intensive therapeutic treatment for psychosis was introduced in the United Kingdom by supporters of the anti-psychiatric movement such as the maverick R.D. Laing and his colleagues (e.g. D. G. Cooper, A. Esterson & J. Berke) at the therapeutic communities of Kingsley Hall and the Arbours Association, these were not sufficiently organised and ultimately gained a bad reputation. However, Laing and his colleagues were leading figures in supporting and promoting intensive psychotherapy for psychosis and their contributions have been exceptional in inspiring many mental health professionals to approach psychosis in comprehensible terms and challenge the traditional psychiatric approach to treatment.

Additionally, more recently cognitive-behavioural therapy has been adjusted for the purposes of psychosis (CBT-p) and more emphasis on individual psychotherapeutic interventions has been cultivated (Hamm et al., 2013). Even though there is a growing body of literature suggesting the effectiveness of CBT-p (e.g. O'Connor & Lecomte, 2011), a large body of evidence also advocates its inefficiency (e.g. McKenna & Kingdon, 2014). At the same time, there has been an increasing interest in the conceptualisation of recovery from psychosis that has given rise to a renewed attention on the role of psychotherapy, with service-user-led organisations – such as the *Hearing Voices Network* – playing a major role in the movement from symptom management to recovery (Cotton & Loewenthal, 2011). The recovery approach with its emphasis on psychotherapy is mainly informed by integrative approaches to psychotherapy such as intersubjectivity informed CBT (e.g. Hasson-Ohayon, 2012), psychoanalytic/intersubjective (e.g. Harder & Folke, 2012), phenomenological/humanistic (e.g. Pienkos & Sass, 2012) and narrative/dialogical

approaches (e.g. Lysaker et al., 2011). Although the effectiveness of symptom-focused approaches such as CBT-p is partly demonstrated by randomised trials, these approaches to psychotherapy are awaiting further rigorous evaluation.

Despite the recent excitement and interest in the aforesaid psychotherapeutic approaches, there is great resistance to their introduction in mental health services. The lively debate about their endorsement as evidence-based practices, the evidence that the development of a therapeutic alliance with this client group appears difficult, and the financial restrictions involved (Hamm et al., 2013) have all contributed towards this resistance. This is notwithstanding the fact that people with psychosis often ask for psychotherapy (e.g. McCabe, Health, Buns, & Priebe, 2002, also argued by user-led research e.g. Faulkner & Layzell, 2000; Thomas & Bracken, 2004). Particularly in the United Kingdom, during the 'acute' phase of psychosis in inpatient settings, CBT-p, family interventions, some adjusted group therapy, art and music therapy are usually employed. The *National Institute for Health and Clinical Excellence* clearly recommends: "Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with psychosis or schizophrenia" (NICE, 2014, p.26). With the psychotherapy for people with psychosis being broadly neglected in general and with present treatments mainly involving the use of medication – and in some cases even electroconvulsive interventions – it is clear that the medical-biological model has not been questioned sufficiently. In this context, the intersubjective aspect this project endorses appear highly pertinent for both the development of psychological and psychotherapeutic interventions but mostly the consideration of the interpersonal processes involved in psychosis.

2.4.2 Therapists' experiences

As has already been shown, the literature on therapists' experiences and processes in their work with psychosis remains scarce, particularly within the phenomenological and counselling psychology literature. In this section, I provide a

brief description of some studies that have dealt with this issue that are predominantly derived from the psychoanalytic and early E-P schools of thought.

The psychotherapy of psychosis does not regularly appear in the CoP literature. There is a significant scarcity of research in exploring how CoPts construct, make sense of and work with psychosis and psychiatric diagnoses in general. Some recent and interesting publications are important to mention here. Larsson (2010) interviewed CoPts working with a diagnosis of 'schizophrenia' with an interest in exploring their general work and found that they had a tendency to negotiate their relationship with their clients, their professional identity and the organizations they worked for. In addition, he found that there were a number of complexities in their relation to the diagnosis of 'schizophrenia', for instance how to negotiate the balance between phenomenology and empiricism. Additionally, Lamproukou (2014) interviewed CoPts working within the NHS and found that while they expressed the experience of a plethora of tensions in their working environment, they also developed a variety of coping strategies to deal with these tensions, such as holding a pluralistic stance, assimilating the medical model with their own value base system and prioritising the clients' needs over the NHS guidelines. What was particularly significant is that all participants had a strong therapeutic identity and reported practicing in accordance with CoP values which mainly prioritise a relational approach and a tendency towards the deconstruction of pathological conceptions. Along similar lines, Davies (2013) interviewed CoPts who worked with clients who had been given a psychiatric diagnosis and found that many participants expressed feelings of uncertainty when working with this diagnosis. The positions the participants adopted in order to deal with uncertainty included a combination of uncritically adopting the diagnosis, challenging the diagnosis, and compromising and avoiding the diagnosis in their efforts to deals with feelings of uncertainty. The researcher concluded that overall the participants lacked confidence in working with diagnosis and struggled to adapt to medical model contexts. Lastly, Larsson, Loewenthal, & Brooks (2012) explored how CoPts working with 'schizophrenia' experienced the work and found that they constructed their experiences of working with these individuals in a 'relational' way by relating to the person's experience and normalizing the experience while there was a particular emphasis on the therapeutic

relationship rather than technique. However, the authors also stressed that the dangers of pathologizing language are always present. What the literature therefore seems to suggest, is that CoPts working with a diagnosis in medical settings such as the NHS, seem to express a certain level of uncertainty, anxiety and ambivalence relating to issues of diagnosis.

What the in-depth exploration of the literature on the psychotherapy for psychosis has demonstrated is that earlier publications are more attentive and explicit on issues concerning the psychotherapist's experience, with early psychoanalytic work (e.g. Fromm-Reichmann, 1954; Searles, 1965; Sullivan, 1962) and early E-P work (e.g. Minkowski, 1933/1970; Rumke, 1941/1990; Binswanger, 1963/1993; Laing, 1965) more keen to engage with this dimension. This lack perhaps reflects Buber's assertion of the incongruity of the relationship in psychotherapy due to a power imbalance between client and therapist. He suggested that there is an asymmetry within the therapeutic encounter in the sense that both the client's and therapist's gazes are usually directed towards the client's condition and not at the therapist's (Friedman, 2002). Even though recent contemporary psychoanalytic literature deals with the countertransference, this body of knowledge is considered to be relatively small (Horowitz, 2002). Traditionally, psychoanalysis employs the notions of transference and countertransference to deal with the therapeutic relationship. However, the epistemological and ontological position this project endorses instead takes a phenomenological and intersubjective position on the relational view of the therapeutic situation and understands it as real. As Cohn (1997) has stressed, the E-P perspective suggests that a person cannot be a screen for the projections of another and does not encourage an impersonal stance from the therapist. Even though a critical appraisal of countertransference from an E-P perspective will not be discussed in this project, some early and later psychoanalytic work regarding the therapists' processes and experiences in the psychotherapy for psychosis (which come close to a phenomenological understanding) are briefly considered.

Interpersonal psychoanalytic accounts on countertransference often report that working with psychosis elicits intense feelings of sadness, despair, terror,

hopelessness, anger, frustration and anguish (e.g. Horowitz, 2002; Baranger & Baranger, 2008; Grinberg, 1962; Heimann, 1950; Langs, 1978; Little, 1951; Kernberg; 1965; Sullivan, 1962). Searles (1965) wrote lengthily on the experience of these feelings and the use of the self in the psychotherapy of psychosis. He strongly recommended that the potential for recovery, which takes place in the therapeutic relationship, concerns both therapist and client. He suggested that the therapist is involved in a dynamic process which entails her personal healing as well and demonstrated through an abundance of case studies how the difficulties of engagement from the therapist side are mainly due to the retrospection and recognition of less healthy parts of herself. However, he demonstrated clearly that this is the condition upon which a therapeutic bond can form. Sullivan (1962) with his interpersonal approach to people with psychosis also demonstrated the *therapist-as-person* approach to psychotherapy with personal involvement, vigorous questioning, and rigorous listening by making use of his own emotional responses. He too believed that the psychological disturbance in psychosis echoes something inherent in everyone. Moreover, Benedetti (1992) a renowned psychoanalytic psychiatrist who worked extensively with psychosis suggested that the suffering a person with psychosis goes through consists of the most severe issues the human mind encounters. "Tackling them means illuminating the human being with signification and sense, gaining a better understanding of the human being in general, not only of the psychotic person" (Benedetti, 1992, p. 15). Fromm-Reichmann (1954) talked extensively along similar lines of the therapist's processes/difficulties and stated that "Psychiatrists can take it for granted now that in principle a workable doctor-patient relationship can be established with the schizophrenic patient. If and when this seems impossible, it is due to the doctor's personality difficulties, not to the patient's psychopathology" (p.91).

Additionally, therapists' understanding of the meaningfulness of their therapeutic interventions and relationships with people with psychosis has been often reported as shaken (Horowitz, 2008). Horowitz (2006) stressed that the therapists' difficulty in creating meaning out of their clients' experiences is of a common feature in work with psychosis: "(…) no therapist immersed in work with the long-term mentally ill is spared the agonising search for a common thread in the swirl of chaos"

(Horowitz, 2006, p. 177). Moreover, therapists' empathic attunement to clients has been described as severely restricted when confronted with experiences within the therapeutic relationships that elicit strong emotions in therapists (Wilson & Lindy, 1994). Apart from the compromises in therapists' empathic and reflective capacities, therapists working with psychosis come across difficulties that relate to a sense of fear in working with this client group even before encountering the client. The common discrimination against people diagnosed with schizophrenia and other psychotic disorders that seems to be common among mental health professionals as well (Thompson et al., 2002), generates a negative climate even before the professional starts working with a client. The generated social stigma towards psychosis according to Benedetti (1987) creates a sense of fear, which in turn creates a form of a generalised social aggression towards the person diagnosed with psychosis with related resistances from the therapists' side and resultant complications in the therapeutic process.

Another noteworthy observation comes from Searles (1961) who has written extensively about the therapist's anxious need to provide 'antidotes' for the clients and rescue them from their circumstances and experiences, particularly in the cases where these experiences provoke extreme amounts of anxiety and terror for the therapist. This experience of terror was also stressed by Fromm-Reichmann (1959) who suggested that persons diagnosed with psychosis embody fundamental elements that the rest of us manage to suppress in order to avoid the experience of the terror they generate; however, by so doing, we miss the opportunity to gain awareness into our own processes. Along these lines, Brody and Farber (1996) explored therapists' attitudes towards their therapeutic relationships and found that despite the excitement and lack of boredom inherent in their work, therapists expressed intense emotions of anxiety, frustration and hopelessness. A multifaceted combination of countertransference responses was also reported, while at times a strong wish to abandon the work and refer clients elsewhere predominated. Additionally, in exploring the beneficial aspects of psychoanalytic psychotherapists' experiences of their work with psychosis, Laufer (2010) proposed that therapists reported transformational and learning experiences in their work. The author highlighted that the majority of her participants shared that their clients taught them something

essential about the human condition. She particularly commented that their experience "(…) reveals our vulnerability, our dependency on each other, and that's very threatening for people. They're just a reminder of how fragile we all are, and that's scary for people" (p. 170).

From the early E-P tradition, some inspirational work includes the work of Minkowski (1933/1970) and Rumke (1941/1990). Rumke introduced the term *praecox feeling* to demonstrate the therapist's difficulty in connecting with people with psychosis, by explaining that it mainly consists of feelings of bodily unease, echoing the detachment and alienation of the client. He placed significant emphasis on embodied intersubjectivity and strongly suggested that the diagnosis of psychosis should be grounded not on individual symptoms but on the difficulties experienced by the therapist with regards to the affective exchange and the bodily feelings arising because of that. As Rumke (1941) has suggested: "As interpersonal relations are not one-sided, the investigator examining a sufferer from schizophrenia notices something out of the order within himself" (p.336). Rumke implied that the therapist's self-relation changes and the experience of rupture in the therapeutic relationship also results due to a failing of engagement from the therapist's side. Minkowski (1933/1970) in a similar fashion with Searles and Fromm-Reichmann suggested that both therapist and client change in the therapeutic relationship. He aspired towards a better understanding of a person's situatedness by immersing himself in his clients' life and sharing their experience and considered that the therapist's own emotional reactions could be used as a precious exploratory and therapeutic 'instrument'.

The revival of phenomenological and intersubjective conceptualisations of psychosis appears to influence diverse psychotherapeutic modalities including the cognitive-behavioural, humanistic, psychoanalytic/psychodynamic and the narrative/dialogical (Lysaker et al., 2011). This has been one of the essential motivations in recruiting psychologists and psychotherapists from diverse modalities for the purposes of this project. As Markin (2014) has pointed out, "It's our relational stance which bridges theoretical differences. It's our concern for the quality of therapeutic relationship which binds our diverse orientations" (p.329). However, I

consider that the contemporary literature on intersubjective approaches to psychosis lacks a detailed examination of the psychotherapist's role and lived experience of psychotherapeutic processes. Even though the majority of contemporary phenomenological literature exhibits a 'two person psychology' it still employs an 'egocentric' position, in the sense that it mainly focuses on the person who receives therapy and considerably ignores the therapist's experience. In the cases where the therapist's experience is considered, more emphasis is placed on her interventions and other-experience rather than the inclusion of a detailed exploration of her lived self-experience as situated in the betweenness of the therapeutic process and how her experience of therapy intersects with the manifestation of psychotic phenomena. Taking into consideration the preceding exploration of intersubjectivity, I suggest that this tendency is to a certain extent anti-intersubjective and calls for reconsideration.

In conclusion, these approaches not only suggest that psychotherapy for psychosis and its recovery are possible but also consider in detail the therapist's involvement and difficulties in the therapeutic process as an inextricable aspect of the psychotherapy of psychosis. They also demonstrate that in order to intersubjectively and meaningfully approach clients' experiences, we must authentically come to grips with aspects of our own selves that we usually tend to avoid because they connect us with painful facts about our vulnerable human condition. Moreover, these approaches suggest that an attentive engagement with clients allows us to rediscover aspects of ourselves, obliterate the separation between 'madness' and 'sanity' and learn about being human and being transformed. Strongly espousing these views and based on my lived experiences, I consider that a deeper understanding of the psychotic state provides the opportunity to rediscover and re-evaluate our notions of self and otherness. As Friedman (2002) has suggested: "(...) the abyss in the patient calls for the abyss, the real, unprotected self in the therapist" (p.190).

2.4.3 Intersubjectivity informed psychotherapy for psychosis

Some of the attempts made in considering intersubjectivity in psychosis from a phenomenological perspective seem to provide a limited and encapsulated conceptualisation of the experience of psychosis. For example, in recent phenomenological literature, the terms *psychotic intersubjectivity* or *schizophrenic intersubjectivity* are introduced in an attempt to conceptualise and define intersubjectivity in psychosis (e.g. Bradfield & Knight, 2008; Bradfield, 2002; Bradfield, 2006). I suggest that this is a deterministic and anti-phenomenological approach: one which provides an encapsulated experience of intersubjectivity in psychosis and is presented as a kind of core symptom from a third-person perspective without properly taking into account the second-person perspective which is relevant for psychotherapy and recovery. Besides, an intersubjectively informed conceptualisation of human distress should challenge the employment of 'symptoms' as are commonly used in the literature. Intersubjectively informed psychotherapy for psychosis must make attempts to comprehend the subjective and intersubjective nature of a person's life-world by exploring the multidimensional architecture of that life-world and gradually establishing a personal and meaningful narrative of it. Rather than treating 'symptoms' it should explore the function of particular irregular fragments in the life-world's architecture and investigate how these contribute towards the existing structure of the whole 'edifice'. The notion of a symptom as employed in the common biomedical, psychiatric and often psychological discourse is acknowledged as a manifestation of pathological functioning. Instead, phenomenologically approached, it is understood not as something to be removed or treated, but as a meaningful component of that architecture which calls for someone's attention and Buberian confirmation. A phenomenological approach attempts to make visible and understand the structural interconnection between psychotic experiences and provide continuity and coherence to them. It requires a kind of understanding that "(...) seeks to find the logos of the phenomena in themselves, not in subpersonal mechanisms" (Fuchs, 2008, p.280). The Heideggerian notion of *aletheia* as unconcealedness seems pertinent here. Heidegger (1926/2001) wrote extensively about the notion of *aletheia* and clarified the significance of a meaningful disclosure of one's ontological 'world' in a process where a personal ontology is being made

accessible and intelligible. Phenomenologically speaking, a symptom, therefore, appears as openness, a dynamic opportunity for deciphering a person's life-world, a portrayal of her ontological essence and a fragment of a person's aletheia. Along these lines, Stanghellini (2013) described the symptom as a salience, a knot in the texture of a person's life-world, like a tear in the matrix. He suggested that it "(...) awakens one's care for oneself in a double sense: since it reflects and reveals alterity in oneself—in it alterity becomes conspicuous; and since from the vantage it offers one can see oneself from another, often radically different and new, perspective" (p.337).

A current revival of phenomenologically and intersubjectively informed psychotherapies for psychosis has been observed (Silverstein & Lysaker, 2009) and while although limited, suggests the primacy of the second-person perspective and puts the therapeutic relationship at the core of the process, which is perceived as the totality of the interpersonal meeting. Phenomenological research evidence not only suggests that mutual recognition is possible through the psychotherapy of psychosis, but further recommends how the establishment of mutuality and 'betweenness' allows the person to develop a more robust pre-reflective self-awareness and a second-person perspective (e.g. Stanghellini & Lysaker, 2007; Nelson & Sass, 2009; Perez-Alvares et al., 2008). For instance, Stanghellini and Lysaker (2007) have examined psychotherapy transcripts of sixty persons with a diagnosis of schizophrenia and argued that the second-person intersubjective approach assisted persons with psychosis in developing strong first and second-person perspectives. Their analysis highlighted the significance of focusing on the here-and-now and the you-and-I of the therapeutic relationship. More specifically they observed that the negotiation of both the therapist's and client's narratives in their betweenness pointed towards shared meaningfulness and was considered essential for recovery. Along similar lines, Stanghellini and Lysaker (2007) suggested that the second-person approach assisted persons with psychosis to recover by opening up their perceptions and expanding their self-experience beyond the experience of self as psychotic. Moreover, Perez-Alvarez, Garcia-Montes, Perona-Garcelan, and Vallina-Fernandez (2008) suggested that their intersubjective commitments to psychotherapy have allowed people with persistent hallucinations to negotiate their relationships with their voices and have

stressed the importance in exploring how the person with hallucinations is engaged in an intentional relationship with his 'object' of hallucination. They concluded that the exploration of the directedness of how a person's consciousness diverts from a shared to a solipsistic world – and how it might be played out in the psychotherapeutic dyad – remains of vital significance from an intersubjective psychotherapeutic perspective.

Additionally, recent research papers and in-depth case studies have suggested that intersubjectively informed psychotherapies which stress the significance of affective reciprocity not only proved this reciprocity possible but further suggest that it supports peoples' journeys toward recovery (e.g. Holma & Aaltonen, 2004; Seikkula et al., 2006; Stanghellini & Lysaker, 2007; Dimaggio et al., 2008; Harder & Folke, 2012; Lysaker et al., 2013; Irarrazaval & Sharim, 2014). Irarrazaval and Sharim (2014) for example, explored persons' biographical milestones of their acute episodes of psychosis and suggested that the intersubjective dimension of their life stories shed light not only on the interpersonal processes involved in psychosis but also in the psychotherapeutic relationship. They have also emphasised that in the cases where therapeutic interventions were delivered throughout the acute phases of psychosis and comprised of efforts to reduce 'positive' symptoms without paying attention to their intersubjective elements, the possibility for relapse was very high.

Although not explicitly informed by phenomenological principles, a fairly recent and exciting approach to psychosis originates from the Western Lapland in Finland, called the 'Open Dialogue' approach, which is based on social constructionist frameworks and dialogical and family therapy principles. The unconventional and intersubjectively oriented 'open dialogue' approach suggests that instead of focusing on particular techniques, the therapeutic team works together with the family and patient (initially on a daily basis, and usually from the patient's home), and focuses mainly on how the patient, her family and the therapists are all involved in dialogical processes. The main aim of the approach is promoting a multi-voiced and democratic dialogue between the patients and their families and/or their significant others. This approach conceptualises psychosis in comprehensible terms and suggests that psychotic phenomena consist of meaningful responses to particular traumatic experiences. The emphasis placed on transparency, the tolerance of

uncertainty for everyone involved in the process (patients, their family and the therapists involved) and the exploratory and subjective approach towards expressed thoughts closely matches some E-P approaches to psychotherapy, such as that of Spinelli (1997), which emphasise the attitude of 'unknowing' in the therapeutic relationship. It is important to note, that the "open dialogue" approach has recently received worldwide attention since a plethora of evidence seems to suggest that its employment prevents young people who present with psychotic difficulties from developing chronic symptoms and needing to use psychotropic medication (e.g. Gromer, 2012; Seikkula & Alakare, 2012).

The revival of phenomenologically and intersubjectively informed psychotherapies for psychosis draws our attention to the possibilities of the psychotherapy for psychosis despite the pessimism evidenced in the literature. Even though a plethora of therapists from diverse theoretical orientations experience the development of the therapeutic relationship as challenging (e.g. Evans-Jones, 2009) evidence also demonstrates good levels of therapeutic relationship (e.g. Hammond, 2004; Dow, 2003; Svensson & Hansson, 1999; Evans-Jones, Peters, & Barker, 2009; Frank & Gunderson, 1990; Startup, Wilding, & Startup, 2006).

2.5 RATIONALE OF THE RESEARCH PROJECT

2.5.1 Research focus

The preceding review has demonstrated the lack of published literature in exploring the lived experiences of CoPts working with psychosis with particular emphasis on intersubjective elements in the therapeutic process. A recent interesting study conducted by Larsson, Loewenthal and Brooks (2012) also stressed this issue. In this study, the researchers employed a critical discursive methodology and interviewed eight counselling psychologists who worked with psychosis, in order to explore their understanding of the diagnosis of schizophrenia. The researchers

concluded that although the CoPts constructed their experiences in a relational manner, the employment of a pathologizing discourse was nevertheless present. The authors emphasised the unrepresented contributions of CoP in the literature and the prominent lack of the exploration of CoPts' experiences in working with this client group. In light of these results and according to the detailed literature search conducted, to my own knowledge, no research study has been conducted until the present, to explicitly explore intersubjective approaches to the psychotherapy of psychosis from a CoP perspective. It was because of these limitations that the rationale for conducting the current study was developed and gradually formed my research question. More specifically, the main research question of this research attempt was: What are CoPts' and psychotherapists' lived experiences of the therapeutic process in working intersubjectively with people with psychosis? Specific emphasis was placed upon the exploration of therapists' self-experience, other-experience and their understanding of the dynamic processes in the space in-between.

2.5.2 Relevance to counselling psychology and psychotherapy

As has been already discussed, this project is not only interested in exploring the lived experiences of CoPts in working with psychosis but also those of psychotherapists, since their experiences may also be of direct relevance to the field of CoP. In this study, psychotherapists identify practising from an intersubjective perspective with a focus on the mutual, and shared an understanding of the client's distress by considering both the client's and the therapist's involvement in the therapeutic relationship. Since both CoPts and psychotherapists are trained to practice within a variety of modalities, with a range of manifestations of severe distress and that this particular way of working and intersubjectivity are also of primal significance to the work of CoPts (Lane & Corrie, 2006), the psychotherapists' reflections are considered valuable. Moreover, given the increasing numbers of CoPts who are now working in settings where they encounter people given a diagnosis of psychosis, the exploration of their self-experience, Other-experience and lived experience of the therapeutic process are significant for the field of CoP. The phenomenological nature of this study can, therefore, provide data and knowledge

which resonates with both CoP's and psychotherapy's practices and which they will both find useful in practice, supervision, and research.

2.5.3 A reflexive account

It is important to firstly mention that I have kept a research/reflexive diary throughout the research as a 'monitoring tool' in order to grasp, record and reflect on as many as possible assumptions and biases, which arose in consciousness throughout all the stages of the research. As Kasket (2012) has addressed, an intrinsic characteristic of the E-P approach to CoP is to bracket one's assumptions and biases as much as possible in both research and practice. In order to attend to this process, one should address these assumptions and reflect upon them. For this reason, the reader of this project should expect to read several forms and levels of the personal reflexivity processes (some have been already presented in the preface) which have mainly derived from my personal reflexivity diary kept throughout the research process. At this particular stage, personal reflexivity is about recognising that the positions I took as the researcher throughout the literature review in a dynamic combination with my previous lived experiences of therapeutic work with psychosis have affected the approach with which I conducted, transcribed and analysed my participants' interviews. For example, I recognise that my own lived experiences in inpatient settings and training in E-P CoP, have impacted the ways in which I have explored the literature, emphasised several authors and constructed my critical attitude towards certain theoretical and clinical approaches. It is, therefore, likely that my experiences had an impact on my expectations of the findings in terms of my assumptions and biases. For instance, before the construction of my interview schedule and the recruitment of participants, I had a strong expectation that the prospective participants would have shared similar concerns with my own around issues of diagnosis, stigma, intersubjectivity and strong therapeutic bonds with people diagnosed with psychosis. These expectations were thoroughly reflected in my reflexive diary and discussed in research supervision in an effort to approach participants' interviews as openly as possible.

I would also like to provide a brief reflexive account regarding the process of constructing the literature review. All preparatory reading and construction of this particular chapter have been very challenging and energy consuming, which employed a lengthy, yet exciting and fruitful period of immersing myself in the literature. However, having been so engaged with the literature, I often wondered if this hard work also informed against the anxiety of approaching a concluding 'truth'. I often had to remind myself that there was no final truth waiting to be discovered amongst the plurality of standpoints I was exposed to. As Spinelli (2014) has addressed, "The existential thought argues that the quest for any fully-realized and permanent coherence, completeness or fulfilment in one's lived experience of being can only ever be just an attempt, a movement towards, rather than an arrival" (p. 8). Moreover, a reflective stance towards my 'bulimic' attitude in the process of discovering, reading and 'digesting' tons of literature, shed light on the underlying tendency to procrastinate and stretch the time boundaries of the projects' time planning. My prolonged engagement with the exploration of the literature felt related to the underlying awareness of my inevitable 'death' as a student and a resistance in taking a leap of faith and moving closer to the possibility of becoming a fully recognised professional, and therefore diving into uncertainty.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

Having already sketched the rationale of this project and reviewed the related literature, the purpose of this chapter is to examine the rationale behind the chosen methodology for exploring my research question. I will clarify how my epistemological standpoint informed the chosen methodology and methods and explain why quantitative methods were rejected in favour of qualitative methods. I will further elucidate why I have chosen Interpretative Phenomenological Analysis (IPA) among the many qualitative approaches available in relation to the epistemological positioning of the research question and continue with an exploration of the philosophical foundations of IPA. What follows is a careful consideration of the most pertinent alternative qualitative methodologies that were finally disregarded in favour of IPA and issues around validity, quality and reflexivity will bring the methodology chapter to an end.

Methodology is the all-encompassing approach to research and includes both philosophy and methods. According to Van Manen (1990) "(…) methodology is the theory behind the method, including the study of what method one should follow and why. The Greek hodos means "way" and methodology means the logos (study) of the method (way). So methodology means "pursuit of knowledge" (p.7-8). This section considers the philosophy and process of pursuing knowledge through a detailed exploration of the methodology of interest and incorporates the consideration and exploration of the underlying research paradigm, the epistemological, ontological and axiological stances that inform the methodology. As Ponterotto (2005) has advocated methodology "(…) refers to the process and procedures of the research (…) research method flows from one's position on ontology, epistemology, and axiology" (p.132). More specifically, this project is based on an interpretivist research paradigm and axiology, endorses subjectivist epistemology and relativist ontology, and employs naturalistic methodology and methods.

3.2 THE BASIS FOR ADOPTING A QUALITATIVE METHODOLOGY

The debate about the efficacy of qualitative versus quantitative methodologies from a CoP vantage point (and in other applied psychologies) is a long-standing one. In the case of CoP, it echoes its often-discussed identity complications and oscillations between the scientist-practitioner and reflective-practitioner positions (that is, between the human and the natural sciences). The conflicted epistemological and ontological positions that CoP is called to contain within both research and practice has given rise to discussions about the pluralistic stance CoP should endorse in both arenas. It suggests that CoPts could effectively use quantitative and qualitative approaches by engaging with methodological pluralism (Hanley, Cutts, Gordon, & Scott, 2013) but also considers how research findings come together with theories of psychological practice (Cooper & McLeod, 2001). The relational and dialogical approach to research and practice which CoP emphasises seems to fit well with the philosophical underpinnings of both methodological and therapeutic pluralism. As Manafi (2010) stressed, CoP has always been tightly grounded in a philosophy that endorses dialectic ways of practising and relational ways of doing research. In other words, I suggest that we are invited to engage our own and other epistemological and ontological assumptions in a dynamic dialogue. This does not negate the possibility of the emergence of incongruity, conflict, and uncertainty. On the contrary, it brings to the fore a vibrant tension with which we are called to engage constructively and creatively by embracing a critical and evaluative stance towards others and our assumptions. As Downing (2000) suggested, this dialectical initiative brings to the surface dilemmas that are not always resolved and the possibility that agreements or synthesis between viewpoints will not always take place.

This project with its emphasis on intersubjectivity from an E-P vantage point employed throughout (understanding of phenomena and therapeutic process, personal reflexivity, collecting data, etc.), endorses a pluralistic philosophy by acknowledging otherness in all its forms. With pluralism suggesting that any significant question can be approached and answered differently (Rescher, 1993), I also acknowledge that different therapeutic approaches have different – of equal value – stories to narrate (hence, the participants of this project practise different therapeutic modalities). With

relevance to methodological pluralism, I acknowledge the otherness of quantitative designs, which have contributed to both counselling and psychotherapy (McLeod, 1994) and therefore respect the usefulness of quantitative approaches for particular types of investigations, for instance when a research question invites large sample sizes and generalisable results with an emphasis on cause-effect relationships. However, the deep exploration of the diversity of meaningful intersubjective experiences this project aspired to engage with invited the consideration of a qualitative investigative position. My decision to employ a qualitative approach was therefore mainly informed by the nature of my research question (what are the lived-experiences of therapists working intersubjectively with psychosis?). Additionally, my personal experiences and values and my training in E-P CoP and its core philosophical values have influenced the genesis of my research question.

CoP is strongly related to the E-P paradigm, which provides a foundation in qualitative research methodologies and their relational epistemologies (Thayer-Bacon et al., 2003). For these reasons, in the next sections I engage with an exploration of the epistemological, ontological, axiological and methodological grounds on which qualitative methods rest, and how these are compatible with E-P CoP, and also whether they fit well for the purposes of my research question. It is important to elucidate that the exploration of the literature also informed the choice of methodology, in the sense that the sophisticated and idiographic nature of intersubjectivity – as the literature indicated – which this project engaged with, could not be explored in quantitative operational terms, hence a qualitative exploration of the subjective nature of the multiplicity of participants' experiences justified the adoption of a qualitative design. Some brief definitions will be useful before delving into the topic. While epistemology is concerned with how we know what we know, ontology is concerned with the nature of reality and being and what can be known about reality. Methodology refers to the process and procedures of research, and axiology is concerned with the role and values of the researcher in the research process (Ponterotto, 2005).

Epistemology

Qualitative methods are based on the interpretive research paradigm, which assumes different points of view that provide distinctive characteristics of a subjectively experienced reality (Kiddler & Fine, 1997). This reminds us of Kierkegaard's (1844/1973) suggestion that we should hold a subjective position towards knowledge of the world and others. Similarly, I make the assumption that the experiences that my participants shared in this study are subjective and therefore the knowledge generated through results provides a subjective knowledge of intersubjective approaches to psychotherapy. Quantitative research methods' positivistic paradigm would have been inappropriate for this project's research question and also incompatible with my personal epistemological positioning, as it assumes that through precise methods the researcher can reveal objective data for an objective reality (McLeod, 2001). The subjectivist epistemology that qualitative methods are based on assumes instead that it is not possible to quantify the subjective nature of feelings, thoughts, and behaviours and considers knowledge to be subjective and contextualised (Langdridge, 2007). This echoes Nietzsche's (1873/1962) criticism of objectivity and truth when he strongly asserted that truth is relational and that we cannot approach any form of absolute truth. Moreover, the researcher is expected to interact with and affect participants and results while being affected herself in the process (Richardson, 1994), which resonates with Buber's (1921/1996) notion of mutuality and intersubjective processes taking place within and between people. This embedded notion of intersubjectivity in the formation of knowledge and the process of research fits well with the second person approach to intersubjectivity upon which this project places emphasis. Moreover, it is incompatible with quantitative methods' objectivist epistemology, which considers that any form of knowledge can be measured in objective terms, with the world experienced and described objectively and the researcher independent from the phenomena of investigation.

Ontology

Ontologically, qualitative methods maintain a relativist approach by rejecting the existence of absolute truth, and assume reality to be subjective, multiple, meaningful and intersubjectively constructed by people (McLeod, 2001; Langdridge, 2007). Husserl (1925/1977) insisted that scientific knowledge cannot be separated from our subjective way of understanding phenomena of the lived-world and therefore implied that our understanding of phenomena is not separated from our own lived experiences. As I have already described in the preface, my own experiences in working with psychosis affected my understanding of psychosis and this influenced the formation of my research question. I am therefore well aware that my assumptions related to the psychotherapy of psychosis have affected my personal style in the interviewing process and the formation of my results. Quantitative methods take a completely different turn with the researcher adopting an ontological position that makes her assume that to avoid biasing the results she needs to remain objectively detached from her participants. This project's research question and my personal epistemological and ontological positioning assume an intersubjective construction of research findings and therefore a research methodology advocating that the researcher should adopt a detached approach towards participants was rejected.

Axiology

The constructivist-interpretivist nature of axiological assumptions in qualitative methods considers the research process and outcomes as value-laden. The implication of considering the researcher's values as an inextricable part of the research process is that it provides the space for their comprehension and challenge (Willig, 2008). E-P thinking places a considerable emphasis on how our speaking position and our values affect the understanding of phenomena under investigation (e.g. Deurzen, 2002). On the contrary, quantitative research's axiological assumptions – which seemed incompatible for this project – assume that the researcher should strive for a value-free and unbiased approach since it views values as emotive and therefore outside of the sphere of scientific interest (Mcleod, 2001).

Methodology

Methodologically, qualitative approaches follow an inductive process of research. They therefore take into consideration the effects of the context throughout the research process while they also assume that both researcher and participant shape the form the results take (Ponterotto, 2005). On the contrary, the deductive process of quantitative methods is involved instead with cause and effect relationships without being sensitive enough to context issues (McLeod, 2001). Instead, this project's emphasis on intersubjective dynamics maintained sensitivity to contextual issues throughout. For example, both my personal and participants' social contexts and the relationships between the two have been considered as significant in the analysis and interpretation of the data which emerged. Along these lines, Heidegger (1926/2001) and Merleau-Ponty (1945/1962) emphasised the importance of context when exploring phenomena by placing particular emphasis on culture, history and time and understood them as the basic structure of human understanding. Moreover, Sartre (1939/1962) has also emphasised the social and political dimension of human understanding.

To conclude, the purpose of this research is to explore the intersubjective experiences of practitioners who work with psychosis. The epistemological, ontological, axiological and methodological stance of CoP (particularly from an E-P perspective), the objectives of this research and the literature review, justified the adoption of a qualitative approach, whereby the generated knowledge was grounded in the subjective and diverse intersubjective experiences of participants.

3.3 EMBRACING THE PHENOMENOLOGICAL METHOD

From the numerous qualitative methodologies available, I have adopted a phenomenological one for this study. As Osborne (1994) has suggested "The majority of qualitative methods have a phenomenological component. The most obvious reason for the shared phenomenological component is the interest in personal perspectives upon experience rather than or in addition to a third-person perspective"

(p.185). This decision was informed by my research initiative (Willig, 2008) in exploring participants' manifold lived intersubjective experiences through a careful consideration of their life-world. Along these lines, Van Manen (1990) emphasised that phenomenological methodologies are mainly concerned about lived experiences. Moreover, as McLeod (2003) has suggested, "(…) the aim of phenomenological research is to achieve an authentic and comprehensive description of the way in which a phenomenon is experienced by a person or group of people" (p. 79). Phenomenology has its origins in European philosophy and is closely related to the work of Edmund Husserl who is considered the founder of contemporary phenomenology (Langdridge, 2007). In this section, I will present an overview of phenomenology, explain the choice of IPA as the chosen methodology by presenting its philosophical and theoretical foundations and show why other possible qualitative methodologies were rejected.

3.3.1 A synopsis of phenomenology

Phenomenology was established by Edmund Husserl and involves "(…) the study of human experience and the way which things are perceived as they appear to consciousness" (Langdridge, 2007, p.10). An essential concept within Husserl's transcendental phenomenology is that of intentionality, to which he paid significant attention (Smith, Flowers, & Larkin, 2009). In other words, he asserted that experience is always an experience of something and that the intentional relationship between what is experienced and the way it is experienced should be of utmost importance for a phenomenologist. Husserl's phenomenological method asserts that in order to approach the real meaning of an experience we need to suspend our assumptions and biases which are universally inextricable aspects of all lived experiences and focus on a detailed description of the experience itself (Smith & Osborn, 2008). For this reason, he introduced the notion of 'epoche' and 'phenomenological reduction' which are conceived as the processes of bracketing one's assumptions about investigated phenomena to be able to grasp and describe them in their 'totality' (Willig, 2008). Moreover, he introduced the concept of

'imaginative variation' which is the process of imagining the experience of inquiry from as many perspectives as possible, to suspend all assumptions and biases of a phenomenon and therefore consider it from the other person's perspective (Langdridge, 2007). In other words, Husserl's transcendental phenomenology was descriptive in nature and its main objective was the focus on the objects of consciousness as they appear in consciousness by suspending what is thought to be known about them (Willig, 2008).

Heidegger, who is also considered as a major figure in the field of phenomenology, was greatly influenced by Husserl but had a quite different viewpoint. He enriched phenomenological philosophy with an alternative interpretive and existential approach instead of Husserl's descriptive one by putting emphasis on the persons' concrete engagement with the world and their inseparability from it (Heidegger, 1926/2001). He suggested that because we are always immersed in the world and since we can never distance ourselves from the world and others, we are always in a process of interpretation. His position contributed towards a 'hermeneutic turn' in phenomenology by suggesting that any phenomenological investigation embraces an embedded interpretive process (Polkinghorne, 1989). For Heidegger, consciousness cannot be separated from the world in order to be examined and understanding the objects of consciousness is not a way we know the world but rather the way we are.

Merleau-Ponty (1945/1962), who also contributed to phenomenological philosophy and particularly hermeneutics, also suggested that we are always immersed in and inseparable from the world and proposed that this is necessary for effectively grasping and making sense of lived experiences. This intersubjective element in his theory, which has been already discussed in the literature review, echoes the value-laden axiological and relativist ontological assumptions of qualitative methods: it assumes the contextual and intersubjective status of reality and truth but also the subjective nature of the researcher's interpretations which are grounded on how her embodied consciousness is attached to the contextual world and therefore determine how she perceives it.

Influenced by both Husserl and Heidegger, another key figure, which contributed towards the hermeneutic turn in phenomenology, was Gadamer (1960/1996) with his project on hermeneutics closely associated with that of Heidegger's. He too understood language, understanding, and interpretation as inseparable structures of our being-in-the-world and suggested that: "(…) understanding occurs in interpreting" (Gadamer, 1960/1996, p.389). Central to his project on interpretation was the concept of 'horizon', which he understood as a scope of vision that incorporates all that is seen and experienced from a particular viewpoint. For Gadamer, the process of interpretation involves a 'fusion of horizons', which as he suggested encompasses a dialectical interplay between the interpreter's assumptions and the meaning of the text (Smith et al., 2009). He understood the process of questioning as an integral part of the interpretive process as it allows the development of multiple horizons.

The phenomenological literature appears divided between a descriptive and an interpretive phenomenology, with Husserlian phenomenologists concentrating on a detailed description of experiences and bracketing of personal assumptions while existential/interpretive phenomenology are interested in hermeneutics and the impossibility of ever reaching the Husserlian reduction. The next section deals with this issue in more detail by examining the basis upon which Interpretative Phenomenological Analysis was chosen as the most appropriate methodology for this project.

3.3.2 The choice of Interpretative Phenomenological Analysis (IPA)

Having reached the decision to employ a phenomenological methodology, my subsequent reflections were related to whether I was going to adopt a descriptive or an interpretative phenomenological method, which would serve the purposes of my research question and my E-P epistemological assumptions. Although all phenomenology is traditionally descriptive and places emphasis on description rather than explanation, it is usually divided into descriptive and interpretative or hermeneutic phenomenology (Finlay, 2012). As Finlay (2011) has stressed, the

descriptive phenomenological approach is the most faithful to Husserlian phenomenology and mainly concentrates on identifying the essence of the phenomenon being investigated through phenomenological reduction (Langdridge, 2007). I consider that the traditional descriptive approach's (e.g. Giorgi's approach, 1970, 1997) emphasis on intentionality and the rigorous description of experience as it emerges in consciousness is very significant. However, the firmness of the descriptive approach in avoiding any form of interpretation by sticking to description seemed incompatible with my own intersubjectively informed epistemology. I have already discussed why I consider Husserl's version of intersubjectivity as missing a core element in terms of disregarding the embeddedness and enmeshment of experience with the world and others, something that the hermeneutic turn in phenomenology has significantly stressed. The interpretive approach does not separate description from interpretation and instead understands interpretation as unavoidable. Mainly informed by Heidegger, Merleau-Ponty, Gadamer and Ricoeur, it emphasises our inescapability from the automatic processes of meaning-making and interpretation. Moreover, it assumes that a complete bracketing of knowledge and past experiences about any investigated phenomenon is impossible (Smith et al., 2009). Abiding by the hermeneutic idea, I considered that a purely descriptive approach was almost impossible to achieve and that my participants' shared experiences of working intersubjectively with psychosis during the interview process were based on a platform that embraced mutual understanding, co-creation and therefore interpretation. Additionally, even though the descriptive approach attempts to engage with experience, it over-relies on the "bracketing" process with little room for the integration of interpretation. The essentially interpretative nature of the phenomena in question (intersubjective experiences) has therefore necessitated a method that can integrate a more active interpretative element. I considered that the descriptive approach was not suitable for this project since it would not allow me to incorporate my personal understandings of the participants' understandings and this intersubjective 'deficiency' discouraged me.

Among other phenomenologically informed methodologies, this project adopted Interpretative Phenomenological Analysis (IPA) as the most appropriate methodology since it is based both on description and interpretation (Smith et al.,

2009). This decision was based on the epistemological and ontological positions of myself as the researcher and hence the project, particularly with the recognition that IPA holds an idiographic approach to research, which is informed by E-P philosophy with emphasis placed on both description and interpretation, subjectivity and intersubjectivity. What follows is the description of IPA's philosophical origins and how its core epistemological and ontological assumptions fit well with the research question of the project.

IPA is a methodology that focuses on a thorough investigation of lived experience and as Smith et al. (2009) explained, it "(…) enables that experience to be expressed in its own terms, rather than according to predefined categories" (Smith et al., 2009, p. 32). My research question invited the exploration of the in-depth experiences of practitioners and also the meaning they attached to these experiences and this clearly meant that I had to recruit a small number of participants in order to be able to explore their experiences in detail. As Smith et al. (2009) stipulated, IPA focuses on people's experiences and their understanding of these experiences or specific phenomena and hence a small sample size is suggested. IPA was also considered appropriate because by paying close attention to individual accounts, it has the potential to disclose interesting and valuable insights for psychotherapeutic practice that challenge assumptions around the psychotherapy for psychosis. As Creswell (1998) suggested, the reality of a set of human experiences could be uncovered through the detailed yet subjective descriptions provided by the research participants.

Another significant factor that contributed towards the adoption of IPA for this project is its emphasis on intersubjectivity and reflexivity, which is aligned with my personal epistemological position in acknowledging the significance of the Buberian 'in-between'. IPA's focus on sense-making within the intersubjective realm emphasises the relational nature of engagement and the processes taking place between participant and researcher. It considers that sense-making is possible because of our enmeshment with the world (Smith, 1996). Even in the cases when sense-making seems challenging, IPA suggests that the researcher should make focusing on the betweenness a priority. Binswanger's contributions to intersubjectivity and the dialogical understanding of a person have also been of great influence to the decision

of adopting IPA. Frie (2010) suggested that he was perhaps the first to apply concepts from phenomenology, hermeneutics and dialogical philosophy to psychiatric and psychotherapeutic theory and practice. Binswanger was clear that the reductionist approach that psychology adheres to, which suggests the split between subject and object – and therefore a split between self and other – should be replaced by a hermeneutic exploration of the person in her life-world by considering how she relates to self and others. His phenomenological approach to the totality of a person suggested a careful reflection on her linguistic, affective, and bodily expressions. His approach to the psychotherapy of psychosis also seems pertinent here. His hermeneutic and existential approach to psychotherapy offers a dynamic conceptualisation of intersubjectivity (as has been already discussed) but also provides an essential framework for relational research. This is attuned to CoP's philosophical values and particularly resonates with its axiological and ontological assumptions. For Binswanger (1963/1993) the Heideggerian 'being-with' and Buberian 'in-between' were fundamental to practice and suggested that we should be concerned with understanding the position and context from which a person's statements make sense. IPA fully adopts this stance and as Smith et al. (2009) suggested, Binswanger's approach "(…) foreshadows the 'insider's perspective' which is one core element of IPA, and the phenomenological turn in recent work with psychosis" (p. 150).

3.3.3 The consideration of alternative methodologies

Despite the fact that my personal E-P assumptions and research question fit well with the adoption of IPA, the process of identifying the most appropriate methodology encompassed a careful examination of other possible methodologies. In this section, I deal with an exploration of Narrative Analysis, Template Analysis, Discourse Analysis and Grounded Theory – which were considered as alternative methodologies – and explanation of the reasons for their rejection.

Narrative Analysis

Narrative Analysis (NA) was also taken into consideration. This methodology is mainly based on the social constructionist epistemology and attempts to analyse the linguistic representation of narrative accounts and reveal their structure by paying close attention to the restrictions and opportunities these structures pose upon human experience (Willig, 2008). The researcher is engaged with a specific experience that is presented in participants' stories through the analysis of the discourse. Smith et al. (2009) recognise that this is an effective methodology for researchers interested in exploring participants' experiences through narrative. Although I acknowledge the emphasis it places upon language and the verbal expressions of participants that can provide clues about their individual ways of sense-making, it was rejected. I considered that its emphasis on linguistic and narrative analysis does not leave enough space for considering how the participant is making sense of her experience. Moreover, interpretation is informed by social theory and for the purposes of my research question, a more comprehensive interpretative approach was preferred.

Template Analysis

Template analysis (TA), which was developed by King (1998), is very similar to IPA in the sense that is engaged with a similar analytical process (semi-structured interview, thematic analysis). However, it is also very different from IPA as it holds a more deductive approach. The themes do not emerge from the data but are pre-selected through the exploration of previous related research and guide the researcher in analysing her data (Langdridge, 2007). In IPA, which is grounded in an inductive method instead, the themes emerge from the data during and not before analysis. What seemed tempting about TA is that the actual phenomena of investigation not only emerge through the literature review but also through the meaning that the participants ascribe to them before the interviews. Before conducting interviews, the researcher administers questionnaires in order to decide upon the themes that she will be subsequently discussing in the interviews (Langdridge, 2007). Although this can allow more participant involvement, upon more reflection I thought that what

precedes the participant involvement (defining the themes from the literature review) counteracts this very involvement. The purpose of the project is to reveal the individual meanings of intersubjective experiences in the psychotherapy of psychosis that are grounded in practitioners' experiences instead of employing pre-selected themes. I was interested in reflecting upon the practitioners' experience though the double hermeneutic concept (I will discuss this later) and therefore recognising the co-creative element of the research process where both researcher and participant are equally involved.

Discourse Analysis

I consider discourse analysis (DA) as a very attractive method from a socio-political standpoint and as has already been shown, the E-P tradition acknowledges the impact of our socio-political situatedness. What I found mainly attractive was the notion of a shared use of language, which it considers as the creator of meaning that constructs our understanding of reality and defines our social roles (Murray, 2008). For this particular project, it would have been interesting to explore how participants employ language for describing their experiences as such an exploration can shed light on the creation and maintenance of psychiatric discourses and the construction of personal and group identities. However, the purpose of this project was to explore how practitioners make sense of their intersubjective experiences and not the ways in which these experiences are narrated based on socially available discourses. DA was finally discarded as a possible methodology because I was mainly interested in exploring participants' experiences from a meaning-making perspective and I considered that my participants' meaning making could have been undervalued with discourse analysis. Also, DA does not embrace a holistic intersubjective approach to language in the sense that is perceived as a social phenomenon as compared to IPA, which holds a more comprehensive approach.

Grounded Theory

It should first be mentioned that the original positivistic approach of grounded theory (GT) proposed by Glaser and Strauss (1967) was rejected for this project, as it is incongruent with my epistemological stance. Instead, Charmaz's version of grounded theory was instead considered for this project, which intends to generate theory (Willig, 2008) and through the exploration of the phenomenon under investigation to provide an exploratory framework. At first glance, the development of an exploratory framework seemed tempting due to the lack of literature for the phenomenon under investigation, but upon further consideration, it was discarded at it strays from the E-P epistemological grounding of my research question. The emphasis on the development of a theoretical framework wouldn't leave much space for grasping in detail the intersubjective experiences of participants. Moreover, one of the main principles of GT is the assumption that within the data there is certainly something to be discovered. My epistemological stance is in conflict with this principle as I am interested in exploring participants' subjective interpretations of their intersubjective experiences and through them revealing in which ways these were different or similar and therefore I do not assume that within the data lies something to be discovered.

Considering the limitations of the above-mentioned methodologies in light of my research question and E-P assumptions, IPA was therefore considered to be the most compatible methodology. The next section deals with the philosophical and theoretical underpinnings of IPA.

3.3.4 Philosophical and theoretical underpinnings of IPA

IPA was developed by the psychologist Jonathan Smith and is primarily grounded on phenomenology, hermeneutics, and idiography. Smith and Eatough (2006) explained that the main purpose of IPA is to deliver a rich analysis of participants' experiences through a consideration of the totality of their life-world. Even though it is informed by the Husserlian descriptive tradition in terms of focusing on the first person perspective, intentionality, and consciousness, it also embraces the hermeneutic turn in phenomenology (already discussed), which is mainly informed by Heideggerian, Merleau-Pontian and Sartrean existential thinking, and Gadamerian and Ricoeurian hermeneutic/interpretative thinking (Smith et al., 2009). IPA considers the fundamentality of intersubjectivity throughout the research process by approaching both participant's and researcher's lived experiences as inseparable from the world and particularly the research context. It therefore assumes a dynamic interplay between them, which meaningfully affects findings. This intersubjective element is integral in IPA's theory of the 'double hermeneutic', which suggests an in-depth exploration of the participant's experiences through the active role of the researcher. It also suggests a mutual interpretative interplay between researcher and participant where "(…) the researcher is trying to make sense of the participants trying to make sense of their world." (Smith & Osborn, 2008, p.53). The 'double hermeneutic' has been a very crucial element in my decision to consider IPA as the most appropriate methodology, considering the project's emphasis on intersubjectivity. I considered that it could assist the interpretation of the multidimensional intersubjective experiences of participants through my intersubjective understandings emerging between the data and myself. This process recognises this because it assumes that all our experiences are intersubjectively situated, as this is fundamental to understanding the other's experience.

IPA is grounded on an idiographic and not a nomothetic approach to knowledge and therefore is not concerned with creating general laws of human experience and behaviour from large samples. Instead, it is focused on a detailed exploration of the participant's subjective experience and therefore recruits small samples. The purpose of the present study is aligned with the idiographic approach

and seeks to provide a thorough exploration of practitioners' experiences that work intersubjectively with psychosis. Therefore, the analysis of results will not be used to generate generalisations. Participants were therefore provided the space to explore in detail their personal understanding of their experiences with an emphasis on what was particularly important about working intersubjectively with psychosis.

Even though IPA is mainly grounded on phenomenology, hermeneutics, and idiography, it is also concerned with cognition and social constructionism. Smith et al. (2009) suggested, "Cognition occurs within the informal, intuitive domain of reflective activity in the natural attitude. It is dynamic, multi-dimensional, affective, embodied, and intricately connected with our engagement with the world" (Smith et al., 2009, p.189). They therefore conceptualise cognitions as being rooted in the realms of interpretation and therefore encourage the exploration of their subjective meaning. Lastly, IPA's emphasis on intersubjectivity and hermeneutics entails an exploration of a person's meaning-making processes, which it understands to be inexorably connected to her linguistic and socio-cultural history. Because of these particular assumptions, it also espouses a 'light' form of social constructionism (Smith et al., 2009). Smith et al. (2009) particularly suggested that IPA recognises that people can revisit and modify the meaning they attach to their experiences through symbolic or cognitive action. Hence, they have implied that the researcher should be attentively taking into consideration the cultural, ethical and political views of her participants in how these might be influencing the way they are making sense of their experiences.

3.3.5 A critical appraisal of IPA

The epistemology upon which this project is grounded anticipates that all sorts of qualitative methodologies have limitations and this does not exclude IPA. As Smith (2011) has suggested, since qualitative research methodologies are quite new in psychology, we can expect alterations and improvements in the years to come. Hence, despite the preference of IPA as the most appropriate methodology, some of its

limitations must be examined, mainly because these limitations must inform considerations around quality and rigour.

Kaptein (2011) and Todorova (2011) have both agreed that IPA is almost completely focused on individual experience and therefore fails to consider the social context within which the experience is situated. Clearly, as has been already demonstrated, IPA's philosophical foundations consider that any kind of experience takes place in a context and is therefore influenced by its dynamics (social, historical and linguistic). Smith himself has considered this criticism reflectively and while he re-emphasised that one of the unique characteristics of IPA includes the detailed exploration of individual lived experience, he encouraged researchers to conduct research that is sensitive to the social context (Smith, 2011). Smith's invitation seems to parallel this project's emphasis on intersubjectivity. Through the analysis of results I have therefore taken into consideration participants' felt-sense of their experiences' 'thrownness' into the social milieu and as socially and intersubjectively situated.

Moreover, Chamberlain (2011) suggested that IPA's methods overemphasise procedural features associated with thematic structures and pointed towards a 'poor' method of analysis. He commented that the prescriptive recommendations which are usually proposed for the analysis of data in IPA are not genuinely informed by hermeneutics but instead guide researchers to search the data closely for 'subthemes', and to, therefore, categorise and connect these into broader 'themes' and present these, supported by data quotations, as the findings.

From an epistemological and theoretical inconsistency perspective, Willig (2013) and Langdridge (2007) have both challenged IPA's reliance on the social cognition paradigm, in other words, its confidence in exploring how a participant employs certain ideas and beliefs to make sense of the world. Having read several IPA research projects, I have also noticed that many of them tend to focus on the cognitive aspect of participants' experiences. Considering this project's epistemological position which focuses on how intersubjective processes are involved in the co-creation of meaning, I was committed to not following a deductive approach to the exploration of participants' cognitions as is usually done in mainstream

psychology, but that I would instead engage in a thorough exploration of their existential implications within the broader conceptualisation and totality of their experiences. As Binswanger has suggested, "Even intersubjective cognition is a kind of (inner) perception, with which we grasp the occurrence of the other mind directly" (as cited in Frie, 2010, p.84). Even though Binswanger's approach seems quite extreme here and to a certain extent incompatible with IPA's epistemological and ontological origins because it is "(…) the version of the phenomenological method that accepts the impossibility of gaining direct access to research participants' life-worlds" (Willig, 2013, p.260), I suggest that not only – to a certain extent – does it echo this project's sensitivity to the intersubjective constitution of self and therefore its cognitions and emotions but it also tackles the subject-object dualism implied by cognitive theory for which IPA has been often critiqued for endorsing. Along similar lines with Binswanger, this project's understanding of perception suggests that the 'inside' is dependent on the 'outside' - that our cognitions are not hermetically sealed within our mind, and that the foundation of our understanding of another employs intersubjective perception and cognition. Even though IPA has often been criticised for over-relying on the idea of internal cognitions that can be accessed, it should be noted that it does not consider cognitions as isolated and separated functions but as an aspect of being-in-the-world (Smith, 1996). My epistemological and ontological stance towards intersubjectivity, which has been informed by IPA's philosophical origins, acknowledges the intersubjective nature of all lived experience and the assumption of the co-creation of experience – and therefore that of cognitions. From an E-P perspective all lived experiences must be understood within the context in which they happen and therefore it was imperative to address how I, as the researcher, have possibly impacted participants' cognitive and affective flow of their narratives. This process was explicitly addressed in the process of analysis of each transcript and some evidence of this will be demonstrated in reflexivity sections extracted from my reflexivity diary.

The consideration of some of the criticism IPA has invited over the years assisted a comprehensive evaluation of its methods. Re-taking into consideration its philosophical and theoretical assumptions in parallel with my research rationale and epistemological position helped me to carefully adjust the methodology to the needs

of the current project – with particular emphasis on intersubjectivity – without turning the methodology to something else by also doing justice to its uniqueness.

3.4 ENSURING QUALITY AND RIGOUR

This section deals with clarifying the particular attention that was paid towards the critical issue of assessing the rigour of the research process throughout, which as Finlay (2006) has suggested consists of one of the major challenges with which qualitative researchers are confronted. Since this is a qualitative piece of work, the conceptualisation of validity, quality and rigour are differentiated from how it is apprehended from a quantitative perspective, which deals with the development of 'objective' knowledge derived from 'objective' realities. The epistemological assumptions of qualitative methodologies that are based on subjective and intersubjective grounds inform therefore the conceptualisation of quality and rigour. Based on Finlay's (2006) and Ballinger's (2006) recommendation for evaluating qualitative research, I particularly refer to the significance of the process of tracking personal bias and bracketing presuppositions, the ethical considerations of participant's otherness (discussed in the methods chapter) and the process of reflexivity (discussed in the next section). Moreover, the project endorses the principles that Yardley (2000) has proposed for ensuring quality in qualitative research, which has been recommended by Smith et al. (2009) and includes sensitivity to context, commitment, and rigour, transparency and coherence, impact and importance, which I address in the following paragraph.

'Sensitivity to context' suggests that the researcher must be very careful in the process of selecting the appropriate methodology and participants. As has already been shown, I have been very thoughtful around the choice of the most appropriate methodology. In the method section I will explain my rationale behind the recruitment criteria and other issues on recruitment that I have thoroughly considered. 'Commitment and rigour' ensure that the researcher is competent enough both in terms of her engagement with the topic but also with her skills in data collection and analysis. I have already clarified how my research question and interest in the

psychotherapy for psychosis emerged because of my personal experiences and intense involvement with people diagnosed with psychosis before conducting this research. In terms of skills in data collection and analysis, I have been in regular supervision with both my primary and secondary supervisors throughout the research process while I also attended seminars, which dealt with issues around data collection and analysis in qualitative methods and IPA in particular. Taking into consideration the criterion of 'Transparency and coherence', I have been aiming for transparency throughout the project by presenting a step-by-step account of all processes involved and making sure that my writing style is coherent, professional and informed by the epistemological and ontological position to which it adhered. Lastly, considering the criterion of 'Impact and importance' that invites the consideration of how the piece of research can be of particular relevance to the professional and research community, I have already shown how my research project can have a powerful impact in the fields of CoP and E-P psychotherapy in both the clinical and research domains, particularly because of the dearth of literature on the subject.

3.5 THE PRIMACY OF REFLEXIVITY

As has been already mentioned and revealed so far, this project has adopted a reflexive stance towards all the stages of the research process (choosing my research topic, preparation of literature review, recruitment, data collection and analysis and discussion of results). As Finlay (2006) has suggested, reflexivity is an essential indicator for evaluating the quality of the research process. This is also in line with IPA's emphasis towards a constant audit of the research process and therefore, I have kept a reflexive diary throughout, noting my biases and assumptions as they manifested in the process, my subjective engagement through the stages, and how this has impacted the hermeneutic process and data. Willig (2001) also stressed the importance of reflexivity and suggested that any qualitative researcher should be thoughtful of both their epistemological and personal reflexivity throughout the process. As has been already demonstrated in this chapter, my own epistemological and ontological assumptions are in line with the philosophical and theoretical

foundations of the chosen methodology and diverge from a positivist understanding of existence. My E-P position has been transparent throughout the process and I am aware that my personal assumptions about knowledge in general and the world, and the relativist ontology and interpretive epistemology I have espoused, have therefore influenced the research throughout. From a personal reflexivity perspective, I am also aware how my personal and professional experiences have influenced the way I have constructed this project, the way in which I have engaged with my participants and the way I have analysed the data. Because of the significance of reflexivity this project advocate, the reader should expect to locate sections of personal reflexivity.

CHAPTER 4: METHODS

The 'Methods' section will deal with a detailed description of the research processes and a thorough consideration of procedures and steps of analysis. A thorough consideration of the adoption of videoconferencing as a method of data collection will be discussed and ethical issues will be considered. The chapter completes with a consideration of personal reflexivity processes throughout the data collection and the phases of analysis.

4.1 SAMPLING, RECRUITMENT AND DEMOGRAPHICS

4.1.1 Sampling

This project employed purposive sampling by selecting a small and homogenous group (Smith et al., 2009) of six participants. In contrast to the random or representative sampling strategies quantitative research usually adopts, IPA focuses on the detailed analysis of the experiences of small samples most suited to the research question (Smith & Osborn, 2003). As Langdridge (2007) suggested, by employing a purposive rather than a random sample more detailed information can be collected about a particular group of people who are considered suitable for the exploration of the examined phenomenon (in this case intersubjectively informed psychotherapy for psychosis). A distinctive feature of IPA consists of its commitment to a detailed interpretative account of the cases included, therefore sacrificing breadth for depth. In the recent past, five, six or seven has been recommended as a reasonable sample size for a student project using IPA (Smith & Osborn, 2008). Even though my initial aim was to recruit between seven to eight participants, the project finally recruited and interviewed six participants due to low response. Notwithstanding the difficulties in recruitment, the richness of the data that was produced through the interviews established that six interviews were sufficient for meaningful analysis to take place.

4.1.2 Inclusion criteria

The project initially aimed at recruiting English speaking, qualified counselling psychologists (registered with the BPS and Health and Care Professions Council (HCPC)) who work intersubjectively with people diagnosed with psychosis on a one-to-one basis. However, as difficulties in recruiting CoPts who work with psychosis were expected (Larsson, Loewenthal, & Brooks, 2012) – the recruitment process resulted in a very low response rate – I subsequently decided to also recruit psychotherapists (registered with the UKCP) who identified themselves as working from a relational/intersubjective vantage point with people diagnosed with psychosis. Moreover, the intersubjective therapeutic stance with which the participants identified was considered more important compared to their therapeutic techniques (e.g., Geekie & Read, 2009) or theoretical orientation. In other words, participants were invited to share their intersubjective experiences from an experiential and not a theoretical perspective. By incorporating a pluralistic stance, the gamut of background trainings and therapeutic orientations was assumed to provide a more comprehensive understanding of the phenomenon under investigation and an association with the existing literature, to facilitate applicability and dissemination. Moreover, the length of participants' post-qualification experience was not considered to be an inclusion criterion because the research question invited participants to reflect on their subjective experiences, irrespectively of their years of clinical practice.

4.1.3 Recruitment

After the project gained ethical approval by both Middlesex University and the New School of Psychotherapy and Counselling (NSPC) (see Appendix I), an advertisement (Appendix II) was created and posted at the Society of Existential Analysis (SEA), the BPS division of Counselling Psychology, and the Universities Psychotherapy and Counselling Association (UPCA) websites. Moreover, the advertisement was forwarded to organisations and charities that campaign for mental health issues such as MIND, SANE, Mental Health Foundation, Mental Health Research UK and Rethink Mental Illness. The International Society for Psychological

and Social Approaches to Psychosis in the United Kingdom (ISPS-UK) was also approached and the advertisement was forwarded through the organisation to connected psychologists and psychotherapists who work with psychosis. A 'snowball sampling' method was also employed whereby participants who already expressed an interest for participating were encouraged to inform other colleagues who also met the selection criteria and could possibly be interested in participating. As Patton (2002, p.243) suggested, snowball sampling "(…) identifies cases of interest from people who know people who know people who know what cases are information-rich, that is, good examples for study, good interview subjects". After several practitioners expressed an interest in participating (by receiving e-mails through a particular e-mail account I created for the purposes of this project: andreas.vassiliou.research@gmail.com), a screening procedure took place in order to make sure that they met the inclusion criteria. It should be noted that the most successful recruitment method proved to be the 'snowball sampling' as four out of the six participants who were recruited were informed and encouraged by the rest of participants who were already taking part and were informed by the advertisement which was forwarded to them by the aforementioned organisations. For those who met the criteria, a 'Participant Information Sheet' (see Appendix III) was firstly forwarded, and after they had carefully reviewed it, a 'Background Information Sheet' (see Appendix IV) and 'Informed Consent Form' (see Appendix V) were forwarded, which they were then encouraged to read carefully, sign, and return electronically. For each participant who agreed to take part in the project, a date and time were then arranged and participants were encouraged to contact me if they had any further enquiries regarding the interview procedure before the actual interview took place. Since at the period of recruitment I was located abroad, I decided to interview participants through videoconferencing (Skype) and therefore agreement upon the place of an interview was not needed. Based on this decision, pre-interview communications were considered fundamental in order consider participants' experience and comfort level with the selected method of data collection and technology. All participants expressed that they were comfortable with videoconferencing, however they were encouraged to make sure that on the actual date of interview that they set up their internet connection, microphone and camera for a smooth videoconference experience. These pre-interview communications were

also aimed at reducing the pressure on both participants and myself and provided the appropriate space for remaining clarifications and proved valuable for developing the relationship needed for a productive and open dialogue throughout the interview. As Finlay and Evans (2008) have stressed, "In this pre-research stage, the foundations of mutual trust within a dialogical relationship need to be put in place and the research aims and process generally agreed upon. In Buber's terms, we are called on to move beyond functional 'I-It' relationship in which we see the other in terms of their use to us, towards an I-Thou relationship – one of openness to their personhood" (p.1).

4.1.4 Demographics

Table 1: Demographic Data

	PARTICIPANT PSEUDONYM	GENDER	AGE	PROFESSION	ETHNIC ORIGINS	THEORETICAL ORIENTATION	CLINICAL EXPERIENCE SECTOR	YEARS OF EXPERIENCE
1.	Paula	Female	31	Counselling Psychologist	White (British)	Integrative	Public (Assertive Outreach Mental Health & Early Intervention Teams)	3
2.	Barbara	Female	38	Psychotherapist	White (Israeli of European origins)	Psychoanalytic	Public (Inpatient, Outpatient, & Rehabilitation Settings)	10
3.	Beth	Female	36	Counselling Psychologist	White (Greek/British)	Integrative	Public (Community Mental Health Team and Residential Care)	7
4.	Carla	Female	58	Psychotherapist	White (Greek)	Phenomenological & Psychoanalytic	Public (Inpatient Settings)	22
5.	George	Male	38	Counselling Psychologist & Psychotherapist	White (German)	Existential-Phenomenological & Psychoanalytic	Public (Inpatient settings) & Private	10
6.	John	Male	62	Psychotherapist	White (British)	Psychoanalytic	Public (Inpatient settings, Residential Care and Early Intervention Services) & Private	32

In the table above (Table 1), I present the main demographic information, which was taken into consideration for the analysis of the data in general. The pluralistic stance this project has endorsed invited both the unique contributions of CoPts and psychotherapists and their diverse theoretical orientations. Participants' professional identities were considered significant in terms of their subjective experiences in working with psychosis and the way in which they made sense of their intersubjective work could have been influenced by these experiences. The exploration of the possible differentiations amongst them was therefore considered important. Also, even though I assumed that participants' shared experiences of their intersubjective work with psychosis were independent of their theoretical orientations (hence they were not invited to conceptualise intersubjectivity from a theoretical point of view per se, but from an experiential perspective instead), these were considered as qualitative indicators of the broader sense-making tendency of their experiences.

Furthermore, in consideration of participants' ethnic origins, the qualitative and phenomenological origins of this project directed a critical focus onto the researcher role and this included race and ethnicity variables which are considered to interact with participant variables and data collected (Springman, Wherry & Notaro, 2006). For example, the fact that all participants shared a White/European origin and a middle-class background was taken into consideration in the analysis of data because it has affected the interview process and data collected: also that I, the researcher, share an ethnic and linguistic background with some participants. Matching researcher and participant ethnic and racial backgrounds have been shown to enhance comfort levels throughout the interview process and increase participants' disclosures (Sherman, 2002). What I noticed with two participants (Beth & Carla) with whom I shared the same mother tongue (Greek) was that they were sharing their vulnerability in a more direct and explicit manner throughout their interview as compared to the rest of the sample. This was perhaps also related to my interview style, which as I have retrospectively reflected upon, was more encouraging in sharing a fuller description of their stream of consciousness by focusing on the here and now of the interview and their emotional temperatures in the process. I am also assuming that the fact that interaction was taking part through a language different from our common first language, being more open in the here and now of the

interview process acted as a compensatory mode for negotiating proximity. Moreover, even though participants' years of clinical experience or settings within which they have worked were not taken into consideration in the inclusion criteria, they were considered demographically significant in exploring how the multiplicity of professional settings (emphasis on context) within which the practitioners gained their experience through the years, could have possibly influenced their intersubjective experiences.

4.2 ETHICAL CONSIDERATIONS

The consideration of ethics consists of a fundamental dimension of qualitative research and this project is in line with the ethical guidelines of the New School of Psychotherapy and Counselling (NSPC), Middlesex University, the British Psychological Society (BPS), and the Health and Care Professions Council (HCPC). Therefore, the BPS's (2014) 'Ethical Code of Human Research Ethics', HCPC's (2015) 'Standards of Proficiency – Practitioner Psychologists', Middlesex University's (2015) 'Code of Practice for Research: Principles and Procedures' and NSPC's (2013) 'Research ethics guidance notes' were thoroughly read and considered throughout all the research processes. It is important to mention again that the project went through NSPC/Middlesex University ethics approval process (Appendix I). Moreover, a Levinasian (Levinas, 1969) perspective that places concern for the other at the centre of ethics is in line with this project's approach and therefore the ethical concerns for the research participants were placed above 'instrumental' processes and procedures. I, therefore, considered it to be imperative throughout the research processes to acknowledge my participants' otherness and treat all of their shared experiences and personal values with respect. I also tried to be as sensitive as possible in my questioning style throughout the interview process with each participant and adapted it accordingly in order to match the particular intersubjective dynamics of each interview.

4.2.1 Anonymity and confidentiality

Participants were not invited to protect details, by not using names or any other identifying details for themselves or their clients, so that their flow of expressivity during the interview remained intact. Therefore, real names and any other details were omitted on their data sheets/files and a coding system was introduced to identify individual participants, in case this was necessary. It should be noted that two of the participants (Beth & George) asked that I exclude from their transcripts some particular information they had shared during their interviews and therefore for purposes of confidentiality these were completely omitted from their original data and are not shown anywhere in the text. Participants were also clearly advised through the 'Informed Consent Form' that excerpts from their transcripts might be published verbatim as anonymous. Moreover, all data were saved both in electronic (stored on a computer with a password known only to the researcher and encrypted methods were applied) and hard copy versions (kept protected in a locked storage). It should be specified that when I refer to the protection of data here, I am referring to research data (interview recordings, questionnaires, transcripts, and coded/analysed data) and participants' personal information collected during the study (consent and background information forms and email addresses). Lastly, all original data will be destroyed after the completion of the study.

4.2.2 Informed Consent

The 'Informed Consent Form' together with the 'Participant Information Sheet' is intended to provide possible participants with clear and simple information about the research project. After the screening process of professionals who showed an interest in participating was completed, informed consent was requested via a signature from all participants who met the inclusion criteria. Moreover, the consent form advised all participants that they had the right to withdraw at any time in the research process. Both the participants and I kept a copy of the signed consent form.

4.2.3 Debriefing

Debriefing is an essential part of qualitative research and as the BPS (2014) specifies, effective debriefing terminates the act of participation, and provides closure for the participant. After the completion of each interview, all participants were referred to the 'Debriefing Form' (Appendix VI) which they had previously received electronically, and were invited to share anything that concerned them about their interview or the research in general. The debriefing was focused on the rights and well-being of the participants and it was intended to make sure that all participants left the interview without having any kind of concerns, uncertainties or questions about their involvement in the interview. Moreover, they were encouraged to contact me if any kind of concern came up upon reflection regarding their participation or if for any reason they felt distressed so that I could offer them a second meeting. It is reasonably assumed that all participants are in supervision – since it is considered a professional requirement and that they, therefore, have a safe space to take any arising issues. It should be noted that no participant has communicated with me after the completion of their interviews.

4.3 DATA COLLECTION

4.3.1 Videoconference as a tool for qualitative research

The decision to conduct interviews via online videoconferencing (Skype) was based on the convenient way it offers for meeting participants, since they are geographically dispersed - including myself as I was based outside the United Kingdom. Skype is inexpensive, geographically flexible, user-friendly and easy to install/use. Moreover, the ease of audio recording was a key benefit, as computer-to-computer conversations were easily recorded with simple additional software. Participants were therefore informed that since the quality of digital recordings by using a separate Dictaphone during Skype videoconferencing may not be clear enough, computer-based recording software was installed which was integrated with Skype and recorded the conversation through an audio mode. More specifically, for

my research, I used 'Call Recorder' software for Macintosh (iMac). 'Call Recorder' is inexpensive and records audio interviews effectively while screening out Internet noise. It was set to automatically record once the Skype conversation commenced and it never failed. It should be also noted that no serious issues with sound quality, microphones, webcam malfunctions or Internet connection speeds took place with any participant during the interviews. In the following sub-sections, I place emphasis on some particularly sensitive issues involving the adoption of videoconferencing as a method of data collection.

Verifying identity and emergency resources

Even though I was not physically present with the participants, their identity was verified through their online presence via videoconference, their e-mail addresses and Skype usernames and passwords. Moreover, in case I had to deal with a participant's emergency situation during the interview (e.g. physical injury, accident, etc.), I made sure that I had access to emergency resources located near the participant's address, such as a significant other or the local police department, which required that the participant's details and location were known.

Security and privacy issues

The exchange of e-mails, in general, can be problematic in terms of privacy, confidentiality and security. As the recruitment process took place through the exchange of e-mails, I was aware of and complied with current legislation regarding unsolicited 'spam' e-mails. Because the security of unencrypted e-mails is low, and e-mail content can be inadvertently disclosed on the Internet or to local and other computers (Car & Sheikh, 2004). To secure emails effectively I encrypted the connection from my email provider, my actual email messages and my stored, cached, and archived email messages received from research participants.

For all interviews, participants and myself were located in our own private space and during the videoconference interaction the participant and myself were the only individuals privately involved in the process. I made sure that no data of the interviews became publicly available in any form, excluding the verbatim excerpts for which participants had given their consent. Moreover the process of online interviewing did not leave permanent records of communication and it is important to specify that no written communication (use of synchronous online chat) took place through Skype during the videoconference. Video teleconferencing, in general, has possibly the lowest potential for increased security and though identity confirmation is not a problem, blocking someone else from interrupting the video stream is typically difficult (Suler, 2004). Skype employs sophisticated video encryption and for the purposes of the current study, some extra security features were employed (Secure Socket Layer). Another potential privacy issue that was addressed was making sure that nobody else was present or likely to walk into my or the participant's room during the interview. Participants were informed about this issue and were advised to take all the necessary steps to ensure that they used a private room during the interview to eliminate the possibility of potential interruptions or distractions taking place.

Working alliance and intersubjectivity

Since the project itself was interested in exploring intersubjectivity, the exploration of embodied subjectivity emerging through videoconferencing was considered significant. My experience of Skype interviewing proved that Videoconferencing offers a conversational quality that most closely matches face-to-face dialogue, and as Salmons (2012) has suggested can be employed with semi-structured or unstructured interview styles without reducing the range or complexity of issues discussed or the emotions of the interviewee. Even though some researchers argue that it may be more challenging to develop a 'working alliance' through videoconferencing (e.g. Ivey, Ivey, & Zalaquett, 2011), my experience proved the opposite. Web cameras usually offer just a 'head shot', which makes it challenging for the researcher to be able to notice body language cues throughout the interview.

For this particular reason, I personally situated myself in front of the camera in a way that permitted almost a whole body capture and also invited participants to situate themselves similarly, in a wider picture mode. This provided the opportunity for a more embodied interaction and with eye contact, gestures and verbal cues all visible, a rich intersubjective exchange was possible.

Langdridge (2007) emphasised the role of the body in the process of interviewing from a phenomenological perspective and suggested that with online interviewing, there is a rupture between self and other. His main argument is that the opportunity to perceive the presence of the other through the full range of senses available can easily be sabotaged through online encounters. However, he did not explore the use of synchronous online methods of engagement through the employment of videoconferencing in his consideration of the significance of corporeality. My experiences of videoconferencing in the interview processes provided the potential to empathically and reflexively attend to my participants' verbal and embodied presence by paying attention to both of our behavioural presentations. In my reflexive diary, I have noted and paid attention to significant embodied responses throughout the interview process, which were crucial for the interpretation and meaning-making processes during the data analysis. The videoconference was therefore experienced as a unique way of interacting for both participants and myself and did not restrict interpersonal understanding. By the end of each interview and during the debriefing process participants were invited to reflect upon their experience of the online interview and all of them shared that it has been a rich experience.

4.3.2 Construction of questionnaire, interviewing schedule and progress

Since the project attempted to explore participants' thoughts, feelings, and narratives in a detailed fashion, a semi-structured interview was conducted with each participant. Smith et al. (2009) suggested that this is the preferred method for data collection in the case of IPA. Open-ended questions were therefore introduced which allowed participants to talk about their experiences in a flexible way. Several prompts

were also prepared for each question and were employed selectively with each participant when they had difficulty navigating around some questions or if they were drifting away from the phenomenon under exploration. The process of preparing the interview schedule (Appendix VII) was informed by the research question and helped to define explicitly what I was hoping to get from my interviews. More specifically, I was explicitly interested in exploring:

- Considering that participants understood the psychotherapy of psychosis as the relational encounter rather than anything else, how do they experience their intersubjective encounters with these people and what meaning do they attach to these experiences?
- How do they understand their relational way of working?
- What is their felt sense of clients and their experiences within the intersubjective space of therapy?
- What kinds of therapists' self-processes are in place within the intersubjective space of therapy?

It must also be noted that the interview schedule was partly restructured after the first pilot interview as new insights were gained and therefore some questions were rephrased or adapted in order to allow a closer exploration of the phenomena being examined. The pilot interview that was undertaken with one of the female participants was significant in that it provided me with the opportunity to become more familiar with the interview schedule and enabled its appropriate reformation in order to ensure that questions and prompts were helpful enough for participants in order to allow access to their relevant experiences. The pilot interview was also significant in that it provided me with the opportunity to reflect upon my interview style. After its transcription and analysis, what became evident was that at times I rushed to impose several questions without allowing the participant the appropriate time to process the questions and reflect on her thoughts and emotions, which mainly resulted because of my anxiety in conducting my first IPA interview. Despite the limitations of the pilot interview, I was able to form a strong alliance with the participant and rich data were therefore generated and I have therefore decided to include it in the study.

I was very aware of the limitations of my interview style in the pilot and the interviews that followed and I tried as much as possible to be patient and provide participants with the appropriate space and time to reflect. I also tried to introduce questions from the interview schedule in the smoothest way possible throughout the interviews as well as further questions that emerged from the conversations, in order to allow participants to elaborate on their responses. The phenomenological exploration of the research questions was situated on the premise of limiting as much as possible personal assumptions and ideas, and to focus on what emerged during the interview process. The aim was to explore the depth and complexity of participants' meaning making by being an active listener and by allowing the participant to lead the interview, rather than my directing it rigidly, based on the interview schedule. Overall, it felt to me that I was able to access what I needed in order to answer my research question and this was not only related to a careful construction of the interview schedule but also due to the strong working alliances that had been developed with participants, which provided them with the appropriate platform to openly share their experiences and related vulnerabilities.

4.4 DATA ANALYSIS

The analysis of transcripts was a long and analytical process however it proved to be the most stimulating and creative part of the research process overall. As Smith et al. (2009) have suggested, the analytic focus of IPA involves the already discussed 'double hermeneutic' principle in which the researcher is trying to make sense of the participant trying to make sense of her experience. My own interpretations and sense-making processes were therefore introduced to participants' experiences and my own lived experiences of being-with the participants. The analytic process included both interrogation and empathy as suggested by Smith and Eatough (2006) and this meant that I was simultaneously involved in a process of attempting to empathically make sense of participants' experiences and their understanding of them and also keeping some distance and adopting a reflective and questioning stance in order to allow further revelations. Moreover, the intersubjective focus of this project encouraged a consideration of the intersubjective dynamics

between the participants and myself as the researcher, which was taken into account throughout the analysis and interpretation of data. Even though I have considered the relationships between participants and myself as an opportunity to emphasise important features of the research topic itself, these have not been presented in the paper as explicitly as I would have wished and this subject will be reflected in the methodological consideration of the discussion chapter.

4.4.1 Transcription

I have personally transcribed all interviews, which was an extremely time-consuming, and at times exhausting procedure. However, it also proved to be a very constructive process, which allowed a dynamic reconnection with not only the interview and connection with participants' narratives and lived experiences but also with my own experiences during the interviews. I created a specific transcript format (Appendix VIII) that felt more comfortable, with margins that provided the space for the introduction of descriptive, linguistic and conceptual commentaries and space for the emerging themes. The transcription of each interview was initiated a day after I conducted it (and lasted on average between 2-3 days), as I wanted to capture participants' lived experience as chronologically close to the interview date I could. This allowed a stronger cognitive and emotional proximity to their narratives and also preserved as much of my reflexive process as possible. In my reflexive diary, I dedicated a specific part to recording my personal processes during the transcription of each interview. What I noticed was that during the transcription process I was sometimes finding it difficult to listen and transcribe my own voice and I was becoming at times self-critical especially in moments when I felt that I had lost opportunities for assisting participants to further elaborate on their own experiences by moving on to something that felt more important to myself. These particular moments were noted and taken into consideration during the analysis of each transcript as they assisted the development of themes.

4.4.2 The steps of data analysis

Smith et al. (2009) made it clear that their recommended steps of analysis do not provide a definite account, with the current literature on analysis not endorsing a definite routine for engaging with the data. However, since it was the first time I was conducting an IPA, I felt that the sufficiently clear steps of analysis Smith et al. (2009) recommended, provided the space for an analytical and reflective engagement with the data, which allowed me to find my way through the process. It is important to specify that I have adopted an ideographic approach, therefore commencing the analysis with a detailed exploration of the first interview transcript before moving to the next one. This assisted the process of becoming as intimate as possible with a participant's experience while each reading provided new understandings. In the remaining part of this section, I present the steps of data analysis that I undertook for each participant's transcript, informed by Smith et al. (2009)'s recommendations.

Exploration of the first interview transcript

Firstly, I carefully listened to the interview while having reference to my reflexive diary, which included notes taken after the completion of the actual interview and notes taken during the transcription. This ensured appropriate bracketing and allowed an explicit consideration of personal biases and assumptions before I immersed myself in the data and started developing themes. It is also important to mention that after the completion of each interview and before transcription, I listened to the interview several times in order to deeply engage with not only the participant's meaning-making processes and lived experiences but also my own meaning-making processes alongside the participant's. This also provided a more embodied engagement with the data. What followed was reading and re-reading the transcript several times in order to detect anything that seemed to be thought provoking or noteworthy. The process of reading and re-reading elicited the first commentary notes which encompassed descriptive comments. I situated these on the right margin of the transcript (describing the content of participant's narrative). The left margins of the transcript included two separate columns with space for linguistic

commentary (focusing on participant's way of communicating experience) and conceptual commentary (an overall interrogative and conceptual engagement with participant's narrative). This process was repeated again and again until I felt comfortable enough with the comments' clearness and comprehensibility. I then gradually started identifying themes (noted in the first left column of the transcript) that came to the fore through the consideration of all commentaries that appeared to provide access to the phenomena under investigation.

Linking the emerging themes

Since the previous process produced numerous themes, on a separate piece of paper I noted all of them and started looking for possible connections amongst them with this process shaping sub-ordinate and super-ordinate themes. Because this process meant that I was working away from the original transcript, sub-ordinate and super-ordinate themes were then double-checked with the original transcript to ensure their consistency with the actual data and the final produced themes were then organised into a table. The interpretative process of producing and listing themes included a consideration of my personal way of making sense of the participant alongside what the participant actually shared. Some of the specific techniques Smith et al. (2009) have suggested for looking for patterns and connections across themes were considered and included *abstraction (*putting like with like and developing a new name for the cluster), *subsumption* (emerging themes becoming super-ordinate themes by attracting other associated themes), *polarisation* (exploring transcripts for oppositional relationships), *contextualisation* (identifying the contextual or narrative elements within an analysis), *numeration* (considering how frequently a theme is supported), and *function* (themes are explored for their function within the transcript). It should be noted that 'Appendix IX' includes a full analysis of the first interview transcript.

Moving on to the remaining transcripts

The previous procedures were employed for all remaining participants and a list of final themes for each participant was then developed. The previously suggested methods in looking for patterns among themes within individual transcripts were also taken into consideration for exploring the connectivity of themes between participants. Each table of themes which was developed for each participant was considered in relation to all other transcripts in order to explore in detail which themes from one transcript was connected to other themes and other transcripts. This complex procedure involved some rearrangement and renaming of themes in order to construct higher order concepts that transcripts shared. I was finally able to produce a table of master themes which I felt provided a comprehensive summary of their experience by mirroring their experience as a whole. A master table with major themes and subthemes for the entire sample is presented as Table 2 in the 'Results' chapter, while a table with relevant excerpts from participants' transcripts corresponding to each major theme and its subthemes is presented in Appendix X.

4.5 REFLEXIVITY, BRACKETING AND PERSONAL BIAS

The phenomenological grounds this project rest on considering the engagement with and bracketing of personal assumptions and biases significant as one immerses oneself into the data. Therefore a reflexive stance was highly significant in terms of assisting the process of engaging with personal biases. Personal reflexivity involves "(…) reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. It also involves thinking about how the research may have affected and possibly changed us, as people and as researchers" (Willig, 2001, p.10). I was therefore more interested in recognising and capturing personal biases by articulating and making sense of them rather than over-concerned about their minimisation. The relativistic nature of my own ontological stance towards intersubjectivity and the psychotherapy for psychosis required reflexive bracketing,

which was focused on making personal values and cultural suppositions transparent prior to conducting interviews. What also assisted this process was the writing of the 'Preface' in which I have reflectively introduced and explored myself as the researcher and author of this piece of work, and how personal experiences have given shape to it. Overall, the reflexive process involved reflexive bracketing which demanded the development of a "thoughtful, conscious self-awareness" (Finlay, 2002, p. 532). Although complete bracketing of personal assumptions was impossible, such bracketing facilitated greater transparency in the research process (Walters, 1995). As Gyulay, Mound and Flanagan (1994, p.33) have stressed, "The investigators disciplined themselves to keep original assumptions and judgments separate in order to remain open to the emerging data. Although it is impossible to be totally free of bias, this technique helps reduce bias".

The initial method which was employed in order to track and engage with personal bias comprised of the practice of reflecting and recording these processes in my reflexive diary, which started in the early stages of the research design, proceeded through the data collection and analysis phases and ended with the project's final interpretative position. One of the major purposes of the diary was to facilitate 'epoche' by being in touch with my reflections and thoughts that I intentionally had to set aside including value judgments of the data. Early notes kept in my reflexive diary included examples of personal experiences of working therapeutically with people diagnosed with psychosis and supervision notes from my clinical work. Moreover, it included reflections of several definitions of intersubjectivity which I came across throughout the exploration of the literature, and how I finally decided to apply the concept for the purposes of the project.

Moving further into the consideration of reflexivity on the process of conducting the interviews, one important issue which needs to be addressed concerns my strong sense that pre-understandings and personal experiences had a positive effect on my interviewing style as they provided the space for more insight throughout the process of assisting participants into a detailed exploration of their own accounts. Having had the experience to work relationally with psychosis in the past, I could partly relate to participants' experiences, which I assume was implicitly

communicated through my responses. Moreover, the process of attending as thoughtfully as possible to participants' narratives was interrupted occasionally. Sometimes a part of me felt detached from participants in my effort to set aside my pre-understandings, while at the same time another part felt fully involved within the intersubjective space of the interview through a dynamic process of participatory sense-making, mutual incorporation, and dialogic connectedness. This dynamic process prompted the necessity to orchestrate the appropriate amount of distance and closeness to participants, which despite its challenges, proved to strengthen my reflective capacities during the interviews and assisted the interaction and cooperativeness between participants and myself. As discussed by Reid, Flowers and Larkin (2005), participant-researcher interaction is a particular strength of IPA as this method explicitly acknowledges its influence in the analytic process. The notion of intersubjectivity, which was employed as a discursive tool, helped to elucidate the complex ways my thinking and feeling were intertwined into the interview process, and thus became an integral part of them. The process of separating personal past knowledge and experiences from participant's accounts has been a significantly challenging task. During the interviews, I often had a strong sense that I was taking up contradictory stances that generated an internal conflict on both a cognitive and an emotional level, which was experienced as an inseparable part of the bracketing process. Below, I present an excerpt taken from my reflexive diary that demonstrates the process of critical self-reflection with regards to the ethics of staying as close as possible to the participant's narrative during the interpretative process:

> *"I am reading again and again the passage in the transcript where Paula is describing her experience of dissociation with a client during a moment of feeling disconnected and struggling to make sense of the client's narrative. I remember vividly where I had a 'eureka' moment and what vibrantly came to mind was Merleau-Ponty's concept of self-alterity. I caught myself in a process of detaching from the participant and indulging myself with reflections on phenomenological approaches to self-alterity. I remember catching myself thinking: Is her expressed difficulty to make sense of her own experience not exclusively caused by something*

external, outside of herself i.e. the client's otherness? Can we say that it's an experience of self-alterity? In other words is she experiencing self as Other in that moment of dissociation? She understands dissociation as an outcome of not being able to make sense and right there in a parallel process I was detaching from her in my effort of what felt like actually making sense of her experience, however in this process I have 'lost' the participant and myself within that space and I did not stay to explore further what was that experience of dissociation like for her and not for me! I lost a big opportunity to help her elaborate on her own experience and I must be careful not to construct meaning out of her own experience devoid of her own contribution in that, when I develop her themes. I must be careful not to represent within her themes an imposition of my own interpretation by using the concept of self-alterity's in a manner which is far away from the core of her experience. But even If I do so, will she appreciate me exploring her experience from that angle, my own otherness, or will she experience it as me being positioned in a way she cannot relate to? More importantly, will she feel that I was not paying enough attention to her story? Have I 'betrayed' her openness? Feeling guilty and confused" (Personal Reflexive Diary, 15th March 2014)

Moreover, being fully involved meant that I was allowing the voices of subjectivity to emerge authentically in coming to an understanding of what the participants meant in their personal accounts. These conflicting polarities often brought strong feelings of vulnerability and helplessness to the fore, connecting me with personal memories of working therapeutically with people experiencing psychosis. A parallel process was taking place that was powerful enough to affect my embodiment at certain moments. Some of the participants' responses and reflections on specific clients that came up during the interviews provoked varying emotional impacts on my own personal recollections of past clients. It was, therefore, helpful to keep detailed notes in my reflexive diary about the emotional impacts "...in order to prevent the worse excesses of the projection of the researcher's own subjectivity in to the research itself and also to maximize the possibility of discovering that which was

otherwise hidden in the data" (Langdridge, 2007, p. 80). Below I present an excerpt taken from my reflexive diary that was recorded right after Carla's interview. It demonstrates a moment of strong dialogic connectedness and my emergent need to disclose a similar experience with the one she was narrating. Even though I had finally decided not to disclose what I was going through while attending to the description of her vivid experience, my own response was recorded and taken into consideration when developing her themes in order to protect the process of theme development from the impact my own past experiences:

> *"Touching and being touched…containing and being contained…I remembered my client* [redacted] *as Carla is speaking here. I remember her eyes as she was expressing how she was emotionally impacted when she kindly touched the client on the shoulder to contain him. I remembered our last meeting with* [redacted] *on the ward before he committed suicide. I felt completely connected to Carla. An experience of merging…I felt that I was containing her but I also felt contained. Tears came to my eyes and I struggled not to share this. I didn't…I should have…I shouldn't…I tried to swallow what I felt and thought. Why did I do that? I had to give Carla the space she needed to explore this. This was not my time. But it was OUR time together. There was so much ambivalence then and now. I crossed my legs and I started coughing. I felt so confused, sad and nostalgic" (Personal Reflexive Diary, 2nd February 2015)*

Despite challenges similar to the one described above, a phenomenological attitude during the interviews helped the bracketing of experiences and pre-understandings of several areas that were explored with participants such as intersubjectivity, delusions, hallucinations, the psychotherapy of psychosis etc. Even though bracketing was never fully achieved, by being cautious and recording my biases supported the analysis of data and my efforts to take an ethical stance towards participants' otherness. My familiarity with the phenomenological method – having being trained in E-P psychotherapy – assisted my interviewing style by focusing on the essences and structure of the phenomena and their underlying universals.

CHAPTER 5: RESULTS

5.1 OVERVIEW

The purpose of this chapter is to provide a comprehensive and clear exploration of the identified major themes in the analysis of data with their accompanied subthemes. Excerpts from all participants' transcripts are employed to demonstrate these (Appendix X). More specifically, Interpretative Phenomenological Analysis (IPA) of the six semi-structured interviews revealed four major themes, which were identified as follows: 1) The primacy of sense-making, 2) A relational approach to therapy, 3) Therapist's processes in the rupture of relatedness and 4) The lived experience of being-with.

Apart from representing the project's research question in the most thorough way possible, the abovementioned themes were predominantly constructed because of their natural emergence from the analytic process. They signified most precisely what the participants communicated about the experiences which were being explored throughout their interviews. It has been clear since I began to immerse myself in the data that my idiosyncratic approach to data analysis and interpretation – and therefore the subjective nature of emerging themes and subthemes – would be the actual strength of this project. It therefore goes without saying that a different researcher would have approached the data in different ways. As it will become evident from the subsequent presentation of results, some themes and subthemes overlap between and within themselves. A careful procedure was undertaken during their development in order to capture this overlap and equal attention has been paid to individual themes and their interrelationships while some have been confidently discarded as they did not fit the overall developing analysis. The relationships between and within themes will become evident in the following sections through the presentation of each one separately and also by paying attention to areas of difference and divergence within subthemes across participants. For the demonstration of results I have described each major theme and subtheme separately and have included excerpts from participants' transcripts in order to support the presentation of each sub-theme. I used the following

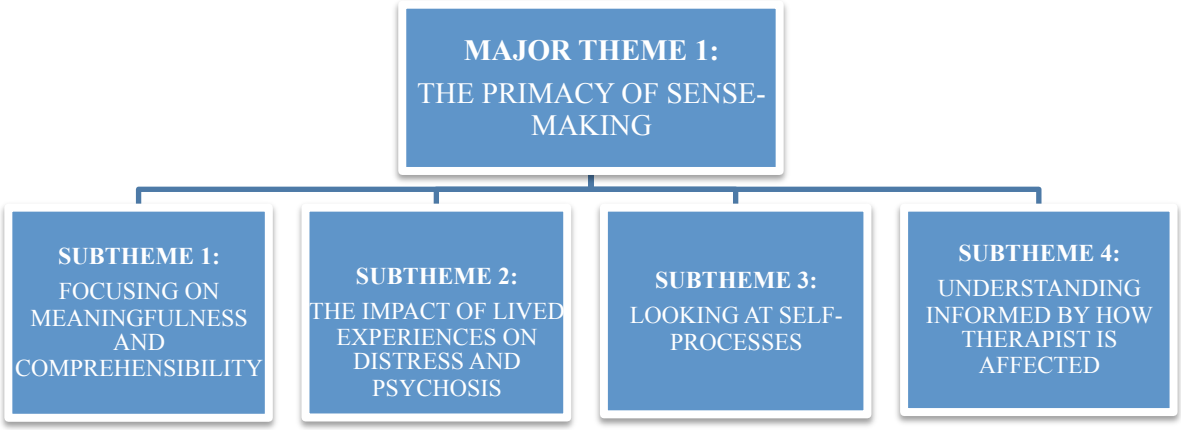
pseudonyms and initials for the participants: Paula (P), Barbara (BA), Beth (BE), Carla (C), George (G) and John (J). Moreover, in Appendix X, I have included a table with all representative excerpts for each subtheme for all participants as due to space limitation it would have been impossible to include all excerpts within the main text of analysis. Readers can, therefore, consult Appendix X for a more comprehensive consideration of the data. Additionally, Paula's (P) full transcript can be found in Appendix VIII and the full analysis of her transcript in Appendix IX. Table 2 below demonstrates the four identified major themes and their accompanied subthemes for all participants with an incorporated checklist, which demonstrates the subthemes that represent participants' experiences. In the remaining section of this chapter, I provide a detailed elaboration of each of the identified major themes and their subthemes.

Table 2: Table of major themes and their subthemes for the entire sample

MAJOR THEME	SUBTHEME	PARTICIPANT					
		P	BA	BE	C	G	J
1. THE PRIMACY OF SENSE-MAKING	1.1 FOCUSING ON MEANINGFULNESS AND COMPREHENSIBILITY	✓	✓	✓	✓	✓	✓
	1.2 THE IMPACT OF LIVED EXPERIENCES ON DISTRESS AND PSYCHOSIS	✓	✓	✓	✓	✓	✓
	1.3 LOOKING AT SELF PROCESSES	✓	✓	✓	✓	✓	✓
	1.4 UNDERSTANDING INFORMED BY HOW THERAPIST IS AFFECTED	✓	✓	✓	✓	✓	✓
2. A RELATIONAL APPROACH TO THERAPY	2.1 PRIORITIZING AND MAPPING RELATIONSHIPS	✓	✓	✓	✓	✓	✓
	2.2 THE USE OF FIRST AND SECOND PERSON PERSPECTIVES		✓	✓	✓	✓	
	2.3 THE FLEXIBILITY OF BOUNDARIES	✓	✓	✓	✓	✓	✓
3. THERAPIST'S PROCESSES IN THE RUPTURE OF RELATEDNESS	3.1 SENSE OF AUTONOMY THREATENED	✓	✓	✓	✓	✓	✓
	3.2 DISRUPTION OF REFLECTIVE CAPACITIES AND CONTRADICTIONS	✓	✓	✓	✓	✓	✓
	3.3 ASSUMING RESPONSIBILITY	✓	✓	✓	✓		✓
	3.4 COMPENSATORY MECHANISMS	✓	✓	✓	✓	✓	✓
4. THE LIVED EXPERIENCE OF BEING-WITH	4.1 RELATEDNESS AND CONNECTIVITY	✓	✓	✓	✓	✓	✓
	4.2 THERAPIST'S SELF-EXPERIENCE	✓	✓	✓	✓	✓	✓
	4.3 OSCILLATIONS BETWEEN DISTANCE AND PROXIMITY	✓	✓	✓	✓	✓	✓
	4.4 BESTOWING MEANING	✓		✓	✓	✓	✓

5.2 MAJOR THEMES AND SUBTHEMES

5.2.1 Major theme 1: The primacy of sense-making



The first major theme was titled 'The primacy of sense-making'. The noun 'primacy' accompanies the notion of 'sense-making' in order to communicate the prominence of comprehensibility for the entire sample. Even though all participants at the beginning of their interviews were invited to share how they understood psychosis, they spent altogether a substantial amount of time throughout their interviews explaining the prominence of making sense of clients' experiences. As will be shown below, they often discussed the experience of making sense because they seemed to perceive this as a vital and challenging part of their clinical work. Moreover, as this project was interested in exploring practitioners' experiences who work intersubjectively with psychosis, it was not surprising that all participants' meaning-making processes were mainly focused on the meaningfulness of psychotic experiences and the impact their clients' lived experiences and relationships with others had on their development and manifestation. Therefore, the first major theme is significant in two ways: Firstly, all participants shared a common focus on the importance of making sense of clients' experiences. Secondly, the understanding of psychosis for these practitioners was concentrated on meaningfulness and function, issues with the sense of self, the impact clients' lived experiences had on their distress and psychosis, and also meaning-building which emerges by reflecting on how the

therapist is affected within the therapeutic relationship. These four emergent subthemes are explored and described in detail below.

5.2.1.1 Subtheme 1: Focusing on meaningfulness and comprehensibility

The first subtheme 'Focusing on meaningfulness and comprehensibility' captures participants' processes in making sense of their clients' experiences. They all passionately demonstrated the thorough attention given to these experiences and how affected they are by them. Despite the related difficulties that were often described by participants, they all seemed to approach experiences in comprehensible terms by not only paying attention to what these subjectively meant for their clients but also what they meant for the therapeutic relationship itself.

> *"Other times is really difficult, but sometimes is easy to reflect upon why it would come about at certain times. Or the fact that is real for her", "So that sort of fantasy gives her a purpose, something quite meaningful and important and actually her life has been empty in many ways (...) so this fantasy is extremely valuable really"* ***(P: P22/L114-115 & P21/L108-111)***

In these passages Paula describes how at times she finds it difficult to attach meaning to clients' experiences but that she acknowledges and validates the subjective nature of her client's experience and the function that it serves. The meaningfulness of her client's fantasy is contextualised and understood as her subjective way of coping with life's difficulties. Participants' difficulties in reflecting about their clients' and their own experiences will be explored in more detail in a following major theme from the angle of reflectivity and relatedness.

> *"Yeah. Also it has a function for them but it also has a story. It tells their story"* ***(B: P17/L61)***

"So it's a question of just gradually making a psychological story that is useful to…rather than these strange bits of biology, and, totally explain it in biological terms. It's actually a psychological one. This makes sense in terms of his life and very…not just intellectually, way of understanding, but that the understanding was highly relevant to his real life issues" ***(J: P22/L187-189)***

"(…) but although it was very, very difficult to understand and it was, emm…it seems like the…basically there was meaning behind the voices and the delusions and that sort of thing" ***(BE: P9/L56-57)***

Barbara, John, and Beth have stressed the function and meaningfulness they ascribed to delusions and hallucinations in a similar way by considering them as narrations of their clients' life stories. John particularly emphasised the psychological value and meaningfulness of his client's paranoia, which he understood as relevant to his real life issues while also de-emphasising biological approaches to psychotic phenomena.

"And then, he, he started feeling that I was, telling me that I was a witch that was doing spells on him. But see everything was meaningful. You know, even though his story sounded crazy, the feelings behind his psychosis were so real. Very real actually. Yes, the feelings were authentic, and I could relate to that", "All the paranoia, the hallucinations in the room, was he, he was creating another persona in the room, one that he preferred compared to the actual person, me, I mean" ***(C: P14/L90-92 & P33/L258-259)***

"But the whole point I'm trying to make here it is about something, it's something about finding meaning in these things and understanding them intersubjectively. So for him the fantasy of a bottle that explodes was something that he brought in to test how far or close he can get to me, whether I could manage his madness, his anxiety and so on", "And then I said something around, I wonder whether it's important to know you can

blow the situation up if it became too much" ***(G: P15/L248-249 & P15/L249-251)***

Carla's and George's understanding of their clients' experiences are explored through particular examples in which their meaningfulness is provided by reflecting on the dynamics within the therapeutic relationship. Carla emphasised that even though she struggled to make sense of the semantics of her client's narrative, the affective component of the story was meaningful, and she could therefore relate to that. She therefore implied the importance of being able to relate at least partly to a client's experience in order for meaning to emerge. Moreover, her understanding of her client's hallucinations and delusions were understood as the client's meaningful response about his experience of the therapeutic relationship. Similarly, George talked about a client who came into a session with a bottle of water, fantasising and threatening that he could explode the room with it. He stressed the importance of understanding the intentions behind this behaviour by approaching it intersubjectively and therefore, for George, sense-making is dependent upon an exploration of what happens between himself and the client. Overall, participants' perception of their clients' difficulties appeared to be dependent upon their manifestation within the dialectical relationship that seems to reveal meaning and function. The process of meaning-building seems therefore mainly contextualised in the present-moment dynamics of the therapeutic relationship.

5.2.1.2 Subtheme 2: The impact of lived experiences on distress and psychosis

The second subtheme illustrates the emphasis all participants gave to the impact of their clients' past and current lived experiences on the formation and maintenance of psychotic experiences, focusing particularly on interpersonal difficulties. More specifically, their process of making sense of clients' distress involved meaningful connections with their past and current relationships, how past traumatic experiences and resultant distress have impacted them and how their current relationships are affected by their present-day difficulties. Overall, all participants

considered relational issues as fundamental in the development of their understanding by pointing towards the impoverishment in interpersonal relationships and they ascribed a basic relational deficit and alienation to their clients' experiences. Moreover, participants understood their clients' distress and described their experiences as not separate from the life context in which they manifest and the contents and meanings of psychotic phenomena were understood within the context of their lives.

> *"She has suffered severe neglect and some degree of abuse although that's not clear, so it's not so clear to work with but loads of attachments difficulties in relationships, family relationships that had broken down, she hasn't been able to maintain a job, so this fantasy is extremely valuable really"* ***(P: P21/L106-111)***.

> *"(…) she was pretty much brought up in* [redacted]*, in the psychiatric hospital, her mother, this is what we were told… She was born in* [redacted]*, then went to some sort of orphanage for kids, and anyway, in and out of* [redacted]*, pretty much it was her home…she had learned to live, she lived with a man at that time, and subversive prostitution, and very severe, well I imagine very severe voices (…)"* ***(BE: P19/L159-163)***

> *"I mean, again the difficulties, I mean he had difficulties in relating to all significant others in his life, he was very, very alone, and it was very sad for me. He went through so many different traumas in life, horrendous experiences and his psychosis exactly, this exactly was, his psychosis was developed in order to deal with all that"* ***(C: P32/L247-249)***

> *"Affect was in the voices. And of course as well as having being on the receiving end of a lot of cruelty and humiliation, it meant he…quite detached from many things (…)"* ***(J: P22/L177-178)***

These passages provide specific examples that demonstrate participants' hypothesis that their clients' traumatic experiences are related to the development of

psychotic phenomena. Paula described how her client's experiences of abuse, neglect and attachment complications within the early family environment were related to his current relational and social difficulties. Her understanding of her client's intense fantasies was informed by how the early traumatic experiences and relational deficits have affected her while she attributed meaningfulness and value to these phenomena, which were understood as a subjective way of coping against her past and current relational complications. Beth similarly made a link between her client's traumatic past experiences, maltreatment and abuse with the experience of auditory hallucinations. Additionally, Carla made a clear link between her client's traumatic experiences and the development of psychotic phenomena by stressing how relational difficulties between her client and others were related to the development of his psychosis in order to deal with his aloneness. Moreover, John suggested that his client's early experiences of being on the receiving end of extreme cruelty and humiliation fragmented his trust towards others and he has therefore developed detachment from others and the world. John's clients' traumatic experiences were associated with the affective states of his auditory hallucinations. John and Carla have further demonstrated their clients' relational difficulties by focusing on their existential aloneness:

> *"(...) what comes to mind is that these patients are often very much on their own, which is both a source of safety and a great pain to them, existentially alone"* ***(J: P28/L235-236)***

> *"(...) if he's very close he's threatened with someone, if he's very far away again he feels that he is left alone. It's very, it's an antiphasis"* ***(C: P4/L20)***

These excerpts stress the emergence of clients' contradicting emotional states in their negotiation of separateness and the need to maintain a safe distance from others to protects their autonomy. I particularly remember John's facial expression and body language while describing his clients' aloneness. A sudden sadness was evident in his tone of voice, and his frowning forehead and clenched lips conveyed an empathic understanding for his clients' struggles. In that moment I strongly felt his

concern for clients and how seriously he takes his work. It also made me wonder what his zealous involvement with this client group might say about his relationship with his own vulnerabilities, a subject I will be dealing with in a subsequent theme.

5.2.1.3 Subtheme 3: Looking at self-processes

The concept of self in general and the disruptions to the client's sense of self and identity in particular was a theme that manifested in all participants' discourses when exploring how they understood their clients' difficulties. The quotes below illustrate that participants understood their clients' disrupted sense of self as linked to issues of autonomy, individuation and the challenges in separating self and other.

> *"Emm, I guess there is a very disrupted sense of self. Sense of identity really that people are lacking, a coherent story about themselves, who they are, apart from those experiences"* ***(P: P9/L30-31)***

> *"I would consider that the build-up towards it will be that some sort of gap started in terms of who they are and the direction of their going and then it was too much so they got psychotic"* ***(BA: P16/L53-55)***

> *"(...) that some people with a diagnosis of psychosis would sit in front of a mirror, and look at themselves a lot. And I was told, oh people with psychosis have difficulty with mirrors and they shouldn't have mirrors and they sit and look at themselves in the mirror. And I thought, I'm wondering why are they doing that. My hypothesis is that they don't know what they look like. Not really, but what I mean is that they have no sense of themselves, or a little sense of themselves (...)"* ***(BE: P37/L378-381)***

Paula shared that one of the common characteristics among her clients is that their sense of self and identity appears disrupted. She particularly talked about their difficulties in making sense of their experiences by constructing a coherent story about

their sense of self. The importance of meaning making is once again exemplified while her clients' struggles in acknowledging who they are apart from their psychosis are highlighted. Similarly, Barbara talked about a 'gap' in terms of her clients' sense of self and how this is related to their directedness towards the world. Beth made an interesting contribution by sharing that she has often witnessed clients spending a considerable amount of time in front of mirrors and inspecting themselves. Her assumption is that clients with psychosis have a diminished sense of self and their lack of being sufficiently reflected by someone is demonstrated by their relationship with a mirror in both a symbolic and pragmatic sense. Her understanding of clients' experiences and behaviours once again demonstrated a dynamic tendency for meaning making even by observations made outside of the therapy room.

Carla, George and John clarified their understanding with regards to clients' fragmented sense of self by paying attention towards the difficulties in individuating and being able to differentiate between themselves and others:

> *"And this is because of the difficulty, often, in differentiating themselves from others, some basic boundaries, yes are not there. So they have a fragmented sense of self, yes, their identity is not whole, constantly disrupted"* ***(C: P6/L28-29)***

> *"(...) to challenge their thinking and to realize what I am experiencing may not be what somebody else is experiencing"* ***(G: P12/L184-185)***

> *"Because well as you know, well sometimes there can be great confusion or loss of boundaries as one of the common features in the more severe psychosis a lot of being unable to differentiate between self and other, (p) (...)"* ***(J: P14/L90-91)***

Carla suggested that the boundaries between self and other are missing and as a result clients' sense of self is experienced as disrupted with subsequent difficulties in negotiating the appropriate distance from others. Along similar lines, John and George argued that the difficulties in differentiating between self and other are

common in their work with George emphasising that part of his therapeutic work with clients is assisting them to regain their autonomy and realise that they have a separate and differentiated mind from others. Overall, in what participants have articulated, it appears that two key difficulties of their clients' self-processes were identified. Paula, Beth and Barbara stressed the understanding of an impoverished sense of self, and Carla, George and John the undifferentiated self.

5.2.1.4 Subtheme 4: Understanding informed by how therapist is affected

The last subtheme of the first major theme captures a fundamental component of participants' meaning making processes and exemplifies the significance of paying attention to the processes within the therapeutic relationship in making sense of clients' experiences. Participants implied that paying close attention to their cognitive and affective changes within sessions and how clients generally affected them assisted the meaning-making process. In the passage below, Barbara illustrates an ambivalent attitude and feelings towards her client, an ambivalence that manifested in her verbal and bodily expressions:

> *"(…) emm…she went from foster house to foster house and she is very…very…spoilt. Emm she is very hurt…and she is sweet…very very sweet. And she creates like people want to adopt her. No, I don't want to adopt her, I have my children and I don't want to adopt her. I wouldn't take her home. And I brought that to supervision. Now this was me talking...with my issue, in front of her, and see the way I felt, rejecting her in a way helped to understand about her own difficulties (…)"* ***(BA: P46/L204-207)***

Observing her bodily reactions and witnessing her emotional shifts through her moment-to-moment expressivity intrigued me. She jumped from her chair and appeared upset as she was describing her client as being spoilt, while in the next sentence as she describes the client as having been hurt and being sweet, her eyes

softened, and seemed to communicate a sense of sadness. The mood seemed to shift again, and with what appeared to be an angry tone in her voice, she described a view about the client's tendency to maintain a particular attitude in her interactions with people by anticipating the possibility of her adoption (having a difficult life background, having been an orphan from a very young age). Barbara, through her vivid symbolism in her discourse declares her difficulty in allowing the client to come closer to her and to assume responsibility for this. By paying close attention to the symbolism of adoption and the great responsibilities an adopter's role entails in pragmatic terms, my interpretation here is that Barbara perhaps struggles to *adopt* a position which protects her role as the therapist by implying that her need to come closer to the client and reflectively engage with her client's need to feel protected, is being sabotaged by a deeper fear. It can be assumed that this generates an internal conflict, which is revealed through her intense mood shifts throughout the passage. She however acknowledged that her response of rejecting the client was a part of her own personal difficulties and emotional defences. Moreover, how she was affected is understood by herself as a way through which she can make better sense of her client's deeper fears by connecting with her expectations of being rejected by a possible 'adopter' but also her lived experience of being an orphan from a very young age and the emergent emotional difficulties. Along similar lines Carla, John and George shared the importance of paying attention to their own processes in the process of making sense of clients' difficulties:

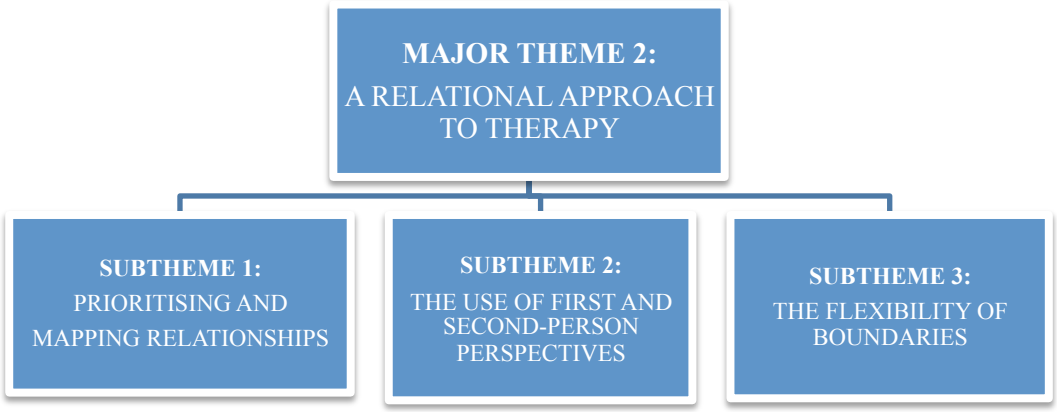
> *"And how the patients affect me, says a lot about how I understand what they are going through, and, yes, also what their psychosis is all about. And how I am affected, you see, says as well a lot about my, (p), yes my own difficulties"* ***(C: P21/L161-162)***

> *"The degree of anxiety or feelings informed me, was very helpful and informed me about the patient's subjectivity (...). The case when one's responses parallel patient's but in this case was such a powerful feeling and that's why I put it together and it told me something about the patient. Suddenly it made me feel much more close to the patient"* ***(J: P21/L394-396)***

"That is the essence of working intersubjectivity. Take his experiential world, bring it into the intersubjective space, and in fact we may have different approaches to it, but using that space to connect me to the person, and how it impacts me tells me what might be going on with them, to then allow them to open their mind further" ***(G: P21/L394-396)***

Carla specified that by paying attention to the way in which her clients affect her she is more able to make sense of their psychosis and related difficulties while also allowing access to her own difficulties and vulnerabilities. Similarly, John shared that by reflecting on his own powerful feelings towards the client helped him to make sense of his subjective world and therefore to ascribe meaning to his experiences. For George the space in-between himself and clients allowed him to connect and attune to their experiential world, which in turn provided an opportunity for making sense of his circumstances and difficulties.

5.2.2 Major theme 2: A relational approach to therapy



The second major theme encompasses the participants' approach to therapy and portrays their unique therapeutic style in the case of working intersubjectively with psychosis. As was anticipated, all participants retained a relational approach to psychotherapy according to their own accounts as to how they work with psychosis; this was anticipated because the project invited practitioners who work

intersubjectively with psychosis. Despite the fact that participants represented diverse theoretical orientations (integrative, psychoanalytic, and existential-phenomenological), they shared remarkable similarities, which demonstrated that their relational approach and deep concerns and emphasis on the dynamics of the therapeutic relationship prevailed over their theoretical differences. Both counselling psychologists and psychotherapists demonstrated in-depth relationships with clients and supported the essential principles of empathy and validation of their clients' experiences and relational difficulties within and outside the therapeutic relationship. This major theme was developed as an outcome of congruent continuation to the previous theme, which dealt with issues of making sense in that all participants' understanding of their clients' difficulties proved to have informed their relational approach to therapy. This theme is also significant as it captures the experiential value of participants' declaration of an intersubjective approach to the psychotherapy of psychosis.

5.2.2.1 Subtheme 1: Prioritising and mapping relationships

The first subtheme deals with participants' emphasis on prioritising and exploring clients' relationships with others but also the therapeutic relationship itself. Even though participants' accounts implied that they tend to work with whatever their clients bring, they also described opportunities in sessions to assist clients in reflecting on their significant relationships. During their interviews participants also seized opportunities to unfold and passionately discuss their relationships with clients, which mirrored their authentic emphasis on relational processes. While in the previous major theme participants demonstrated their understanding of psychosis with clients' relational difficulties highlighted, in this subtheme participants discussed how their therapeutic approach is informed by their thoughtfulness and emphasis towards relational difficulties and how they therapeutically engage to deal with them.

> *"And it was I guess this was something that we talked not only with me but with the team as well and how he related to the team generally, that he*

would engage and form relationships and to open up about his experiences and then he pulled back. So it's about sort of noticing that with him (...)" ***(P: P17/L87-90)***

"But for me, the main work, and she did, and she is in a very different place now, and the main work was, with her peers (...) We were sort of observing what happens for her there and looking at it" ***(BA: P81/L415-417)***

"(...) but you know, this, I really also took into account how he related to everybody else in the residential home (...)" ***(BE: P23/L258-259)***

"We went from there and in the end we managed to get to what was really at hand, which is putting boundaries in relationships. There have been none with his relationship with parents (...) we thought about different ways of disconnecting" ***(G: P15/L270-273)***

In these passages Paula, Barbara, Beth and George expressed their therapeutic emphasis on their clients' intimate relationships. All of them have stressed the importance of inviting clients to explore how they related with others, which was understood as part of their relational approach. All participants have also placed emphasis on their tendency to prioritise and explore relational processes within the therapeutic relationship during sessions:

"It would come up in the process. Noticing patterns, the here and now statements and what happens between us" ***(P: P38/L178)***

"What I, what I consider very interrelational, emm...is, I, use myself a lot. And, and the work. So, my relationship with them, you know, how they view me, or how I view them, emm…or you know, when they shout, how I'd feel, or you know (...)" ***(BE: P15/L111-113)***

"(...) talking about that, you know, talking about us, what's missing, what's not there" ***(BA: P81/L411)***

*"So, I mean I suppose, a simple answer is in a way being prepared to voice out what's happening in the interface between us. If there is something which needs thought" (****J: P26/L220-221)***

"(...) our relationship is vital, and it happens right there, there, so yes, we take considerable time to see what happens between us" ***(C: P19/L145)***

All participants have demonstrated through several examples how interrelatedness is put into perspective and given prominence for exploration during sessions, while a sense of cooperativeness with clients is communicated. By sharing with clients how their experiences impact them, the focus of participants' work seems directed towards the relationship's dynamics while the therapeutic focus on reflecting on the relationship's limitations and how to make best use of the relational space prevails. As appears evident in the excerpts, the importance of focusing on the space in-between and voicing how participants make sense of the interface between themselves and clients is emphasised.

5.2.2.2 Subtheme 2: The use of first and second-person perspectives

The second subtheme deals with participants' use of first and second person perspectives during sessions. The therapeutic processes explored were found to involve the provision of an intersubjective space where therapists were often mirroring and reflecting clients by communicating from the position of the second person perspective how clients appeared to them and how they understood their experiences but also how they made sense of the therapeutic relationship. Additionally, participants illustrated through several examples the importance of using the first person perspective particularly through their use of self:

"So I would bring my opinion, I would bring the way I perceive sometimes the way I...feel about them, "And for him to really know what I feel towards him, to be aware of what I think about him and how I am with him" ***(BA: P48/L225 & P53/L248)***

"So I would, you know, bring up you know, on occasions when I thought was helpful, a feeling, you know I was whatever, how they made me feel, and always explain why I did it", "(...) so with this last example is that I used myself more than I would with someone else who hasn't got so many paranoid thoughts. I brought more of what I was thinking into the play. So yes maybe I use myself a bit more with people that are more paranoid" ***(BE: P44/L454-456 & P15/L116-117)***

*"I would let him know how I am affected by his stories, his feelings, their, yes (p). Because it is very important to let him know how he affects me, and us, the dyad, he hasn't learned that so far in life. If he knows how I am affected he is more able to understand his own position between the two of us (...)"****(C: P18/L132-134)***

All participants have demonstrated their deliberate openness towards clients through a thoughtful use of self, by sharing how their clients affect them in the first person perspective. The above passages demonstrate how participants valued their transparency to clients and how they have understood this as a learning experience for clients. Participants' attempts in sharing with clients their cognitive and affective states portray their relational approach but also their own availability and authentic presence. Even though they have mainly understood their use of self and self-disclosures as parts of their authentic responses towards clients, I tentatively suggest the possibility that these self-disclosures could also be understood as participants' efforts to be revealed as an Other in the therapeutic relationship. Considering participants' emphasis on issues around clients' undifferentiated sense of self and how strongly this impacts the therapeutic relationship (explored in detail in a subsequent subtheme), self-disclosures could be understood as critical processes in which the client is confronted with the therapist's otherness.

The use of second person perspective/mirroring was also stressed:

> *"(…) and I kept on saying well you know, I can see someone who is feeling anxious and you know I can see that from your brows, or from your sweat or you know because I was trained in that way. Or your eyes are doing this and your face looks a little bit more red, looks you've got more blood in your head, you got emotional or whatever, or you're anxious. And yes, to me it was working, getting him to develop slowly his sense of self, by me reflecting what I see and slowly, slowly believing what I was seeing (…)"* ***(BE: P40/L406-409)***

> *"(…) I mean I would do a lot of mirroring and describe to him what I see, and how I see him, and what I reckon he is experiencing etc."* ***(C: P19/L142)***

Participants' use of first and second person perspectives is closely linked to the subtheme that dealt with participants' hypothesis on clients' impoverished sense of self. Participants' understanding of clients' impoverished sense of self and difficulties in differentiating between others are exemplified in participants' relational approach to therapy and particularly through the use of first and second person perspectives. This is considered to assist clients in developing a more coherent and stable sense of self. This is also exemplified in George's passage below in which he stressed the importance of the second-person perspective in helping his clients to develop an awareness of their impact on others and therefore developing a capacity for perceiving themselves as separated from others and maintaining a stronger sense of autonomy:

> *"I use my own response to the person, the patient, to inform what I think is going on with them, I sometimes use my own reaction to them to help them to make sense of experiences, which with some psychotic people can be helpful because they often have no awareness of the impact they have on others"* ***(G: P14/L216-218)***

5.2.2.3 Subtheme 3: The flexibility of boundaries

The last subtheme of the current theme deals with participants' articulated tendency to adjust the therapeutic boundaries of their work, which were found to extend beyond the space of actual therapy. This proved to be an extension of their relational approach to therapy but additionally it has proven to be affected by the context within which participants found themselves working. Participants' flexibility was therefore understood as a response to the multi-layered challenges they came across within their working environments but also resulted from the particular challenges which manifested in their work with psychosis which appeared in congruence with their relational approach, in their effort to reach their clients. While participants found these adjustments of boundaries congruent with their therapeutic approach they often mentioned or implied several accompanying challenges that will be further explored in the following major theme that deals with contradictions.

Carla, who is based at an inpatient ward, communicated her understanding of how her work settings affect the therapeutic boundaries. Her understanding is that someone who works with clients manifesting psychotic difficulties must be prepared to work more flexibly as compared to working with other client groups. She therefore considered it as an indisputable part of her work:

> *"You see, the settings someone works in are very powerful. I mean, yes, so I see the patient outside of the therapy room, because I can't and they can't avoid it. And sometimes it's helpful but other times no. So the boundaries are different, change, and on the other hand you can't do something differently. Working with psychosis needs to, someone needs to be prepared to challenge their boundaries, yes, I mean you can see from this very example"* ***(C: P31/L230-233)***

In the passage below, Paula described how her client's emotional difficulties in committing to a therapeutic contract were contained by the service she worked at (Assertive Outreach Team), which offered flexible support for clients with longer term needs. Paula explained that the flexibility of settings provided the client a safe

and stable platform that could absorb his inconsistency and respond according to his needs:

> *"But it felt that it was a huge thing for him to start to open up all of those details so he would...he back off and then he would engage and my team allows the possibility for that, than I am there available. I mean in the team we hold a caseload of 100 clients that would disengage and engage again. So he disengaged and said he didn't want to work anymore but then he wanted to come back in and wanted to reengage with psychology"* ***(P: P17/L84-87)***

Barbara also described the flexibility of boundaries by explaining how involved she felt in her clients' lives and by providing examples of working alongside her clients' parents:

> *"(...) I do case presentations, so we are very involved in their life. With their parents, and there are parents' meetings at times. So we are very involved in their lives", "(...) they have therapy twice a week with their personal therapist, groups and all kind of other things. So we see them twice a week for 45 minutes. And then in the kitchen, and in the field trips and in parties etc etc etc. But that's our time with them"* ***(BA: P81/L420 & P40/L175-176)***

Barbara mentioned that she gets the chance to see and socialise with clients outside of the therapeutic setting which although not an explicit part of her responsibilities is something that she naturally does and which is partly inevitable due to her work environment (inpatient rehabilitation centre). In the first passage Barbara repeated twice that she felt very involved in her clients' lives. This repetition of her perceived role exemplifies the sense of being too involved, which will be explored in the following major theme in dealing with participants' processes in the rupture of relatedness and their emotional responses in the process of negotiating a distance from clients. In a quite similar incidence when George decided to accompany his client to the hospital for an appointment, he described the power of that experience. He declares

the importance of adjusting his approach to the client by engaging in a dialogue and participating in his linguistic meanings and therefore assisting him to feel safe by containing his disempowerment. This is explained in the passage below:

> *"And because he had such a sense of disempowerment, I agreed with the care coordinator and the psychiatrist that I was going to get him* [redacted] *...we had already spent hours getting there because underground was not an option, we took the bus and I had to sit next to him on the bus and there was a promise, and while on the bus we had an agreement, we had to talk about horror movies because for whatever reason this made him feel safe. So we were on the bus, talking very loudly about horror movies (...)"* ***(G: P15/L253-259)***

Beth also explained how she found it helpful to be more present in her clients' life. Even though the examples she provided below seemed part of her role at the residential home she worked at, she considered this level of flexibility as an essential part of her therapist's role, which provided her with the opportunity to bring more of herself to the therapeutic relationship, congruent with her relational philosophy of the psychotherapy for psychosis:

> *"(...) you know how very helpful it is to be more present, and bring yourself more to the relationship and because we didn't just do therapy together, we, I also go for coffee with the other residents, which is part of them getting out in the community, and we also go to meetings for them, to find a job, or going to a group, or to the theatre, so my role isn't just to do the therapy and go. They see me in other realms, so we sit in the kitchen and have a coffee, and then we do therapy"* ***(BE: P24/L275-277)***

John also provided examples that demonstrated his active involvement in his clients' life. Below he described his spontaneous and authentic gesture in assisting his client with moving home during a period of crisis in her life:

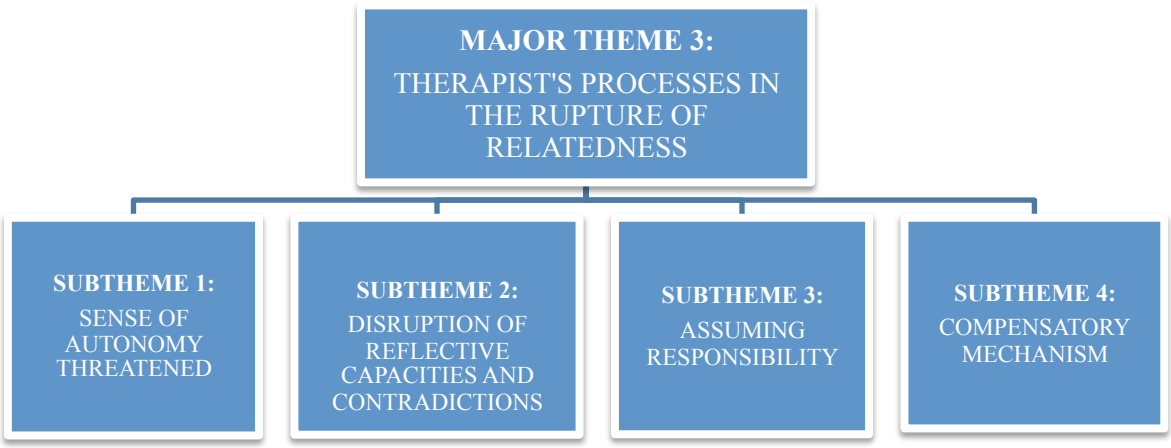
"(...) sometimes a spontaneous gesture in which one does something outside of the norm that can be helpful. I don't do this in a planned way, but I can remember working with an asylum seeker patient with psychosis who had, who was very on the edge…emm…and I think she was pregnant at the time and suddenly there was a crisis and she had to move at the weekend, and having got any sort of facilities and no money and things like that and I found myself with the care coordinator actually physically helping her move some heavy, you know washing machine you know things like that from one thing to another, and that meant a lot to her that I was prepared to do that" ***(J: P12/L77-81)***

John understood his response to be helpful as it meant a lot to his client and he indicated similarly to Carla about a therapist's preparedness in being more flexible and available to clients. Moreover, he provided another example when he went for a walk with a client and explained how important that has been for the client who lacks the experience of someone responding to him with care and emotional availability:

"(...) one day I went for a walk with him for a session, and I can't remember the circumstances that provoked that but just seemed the right thing to do, talk to him in a less formal setting and that meant an enormous amount to him (...) but this gesture I think means a lot to patients, who have lacked that experience of having a genuine, people being out there for them" ***(J: P13/L83-87)***

Overall, all the examples that participants have shared, stressed the recognition of the importance of these events in the clients' lives, but also the therapists' role as human beings and supporting the client to achieve what are routine activities of human life. This exposes just how damaging psychosis can be, and how it affects the clients lives, such that the therapists support the clients in this way that is outside the usual realm of therapy, yet is perhaps necessary as part of a caring profession.

5.2.3 Major theme 3: Therapist's processes in the rupture of relatedness



Moving on to the third major theme and dealing with participants' processes during the experience of rupture in their relatedness to clients, the focus shifts mainly towards noteworthy moment-to-moment therapeutic processes. Even though the ruptures in participants' relationships with clients have been experienced and described in multifaceted ways, their experiences of rupture generally capture the sense of emotional disconnection from clients. The analysis of finding has revealed four distinctive and common categories of experiences. These comprise of a shared sense that their autonomy was under threat, a related disruption of their reflective capacities during sessions, parallel reflective disruptions of reflectivity during their interviews and the tendency to assume responsibility for the experienced ruptures. Lastly, several compensatory mechanisms of dealing with these difficulties were assumed, which involved the employment of diagnostic and psychiatric discourses during the interviews – which seemed incongruent with their perceived relational approach – and a perceived sense of 'specialness'.

5.2.3.1 Subtheme 1: Sense of autonomy threatened

The first subtheme deals with participants' sense of being under threat on both an affective and cognitive level. For the majority of participants for instance, a fragmentation of a coherent gestalt of their experiences during sessions was noticeable which was understood as affecting their attunement to clients with a resultant disturbance of their self-experience during critical moments. Moreover, all participants' autonomous processes of sense-making were experienced as being attacked at some point during sessions, while they all experienced moments in which their lived experience became doubtful with disruptions in the flow of their affective experience. Participants' subjective sense of autonomy violations was therefore understood as synonymous with their diverse experiences of being intruded upon by clients. In the following passages Paula described her subjective experience of dissociation during a moment of disconnection from her client:

> *"I think it makes me back off a bit. Probably, erm even to a degree, it might sound extreme but sort of dissociate a little bit. I guess I see myself from as her. Finding it very difficult to make sense of what I am sort of seeing. I guess I feel something's thrown at me"* ***(P: P28/L141-143)***

This excerpt exemplifies the multi-layered challenges and related paradoxes of feeling disconnected from clients. When Paula was invited to reflect on her experiences of not being able to relate to her client she expressed feeling frustrated which in turn was closely related to disengagement. She described the experience of dissociation as relating to her disconnection and her difficulty in making sense of what was experienced in the there and then. What is also significant to note here is Paula's gaze, which in a way seemed to parallel her dissociative experience by appearing lost in the room while describing her experience of dissociation, and therefore stressed the significance of what was shared. Her expressed detachment from the client and her own cognitive and affective states appear related to what was happening in the space in-between. In other words, the experience of alienation and separateness in the space in-between seems related to a destabilisation in her sense of self and self-experience. Moreover, what appears paradoxical in a sense is that even though Paula's description was of an experience of disconnection, she describes how in that moment she might have perceived herself through the client – which implies a

level of attunement with her client's state. The quote "I guess I feel something's thrown at me*"* implies that Paula's autonomy was shaken, feeling that something was thrown at her from the client, with her self-experience estranged from what she already knew. On the other hand, her expressed paradoxical attunement with the client bombards her with something that is unfamiliar and yet greatly affecting. The experience of dissociation might point towards an altered state of self-consciousness or perhaps a connection with an affective state, which is newly acknowledged yet causes confusion and is subjectively experienced as intruding on her own autonomy. While the previous passage describes an experience of dissociation when feeling disconnected from a client, in the passage below Carla shared her experience of depersonalisation in response to similar difficulties:

> *"(...) really, I couldn't bear the fact that we came closer. I remember vividly that I had some moments of depersonalization in that session. I mean, gosh, I am sure I sound like a psychotic here, but that is the point actually. That this client allowed me the opportunity to sit further with my own difficulties in relating. I remember at some point observing my hands, I don't know, it felt like I wanted to make sure it was me there. I wasn't sure how I felt, my thinking felt attacked, I lost the client inside me", "But it was clear to me afterwards that something happened with my autonomy. See, my, my autonomy was shaken to say the least. Gosh, it was difficult. Very difficult"* ***(C: P16/L110-111 & P15, L/100-103)***

Carla expressed her emotional difficulties, which resulted after coming closer to her client in both a physical and an emotional sense. "I couldn't bear the fact that we came closer" indicates that this experience of coming closer was something to be avoided and therefore she felt 'trapped' in that moment of emotional intimacy. But why did Carla feel so threatened by this relational moment? What has that moment stirred in her? According to Carla, what followed in that session were several moments of depersonalisation. Carla explained that this experience of depersonalisation that followed the strong relational moment shed light on her own difficulties in relating. She described in more detail the experience of depersonalisation, which resulted in a kind of disembodiment, by vividly

remembering herself inspecting her hands as a way for confirming her body, her existence in the room. Confused about her affective state at that moment she felt her thinking was under attack while she declared that she lost her client from inside her, which explains the experience of alienation from the client. Carla has therefore described how her transformation of self-experience which related to both her detachment from the client and herself was associated with feeling divorced from her own personal physicality and her cognitive and affective states. Her perceptual consciousness appeared as a process embedded in the dialectical relationship with her client, which was experienced as an intense disruption of her autonomy. Additionally, Barbara's and Beth's descriptions below also illustrate the experience of autonomy disruptions:

> *"No. No. All I said is that I am not a hugging person etc. When we talked for the 8 hours no. I kind of understood that this is not what I can bring to her, at least not at this stage. This was too much for me, it was already an intrusion", "If what was going on is the lack of connectivity and I feel threatened possibly by it, then I'm tensed. It's both. And threatened, in the sense that I don't know what's happening, where it's me, the client, something strange. Sometimes it feels like, when not connected, that the client will cause something in me…not actually, but you know"* ***(BA: P94/L486-488 & BA P47/L214-215)***

> *"(…) so I have explained very clearly, so this thing was very present, that I wasn't interested in a relationship with him, and why, and yes, this was too much for me, boundaries were shaken, and so, and this was, intruding"* ***(BE: P23/L262-265)***

Barbara stressed how intruded upon she felt by her client's presence (referring to her self-harming client discussed earlier). Even though the client had never asked for physical proximity, Barbara felt the need to communicate that she was not a hugging person, which seems to express a need for protecting her physical space and autonomy from such a possibility. Moreover, in the second quote, she made a clear link between her experience of disconnection from this particular client and a sense of

threat. When Barbara felt disconnected from her client there was anticipation that something unknown and threatening would have emerged and therefore there was an expectation that she had to protect herself in maintaining her autonomy. By also feeling intruded upon by a client who had expressed his sexual interest towards her, Beth articulated her frustration and shared how she experienced the blurred therapeutic boundaries. Along similar lines, John and George demonstrated the impact of therapeutic ruptures on them:

> *"So it's inevitable that (p) almost inevitable that the distortions will appear and manifest themselves in the intersubjective relationship with the therapist. As well as of course with family members and those distortions can be, can cause problems in their own right for myself as a therapist. It can be distressing, disturbing, confusing, painful, shameful, humiliating, intruding, so an essential capacity of the therapist is to do what they can to contain the impact of the distortions within themselves, manage them..."* ***(J: P7/L25-28)***

> *"When it becomes overwhelming for me, so I'm on a physical level a very freaky person. I'm very up-close with people, I'm very touchy. That doesn't bother me. It starts to bother me when I sense that there is a complete dissolution of boundaries, and when I actually start feeling that this is going a bit mad and when I actually start to experience a full sense of madness which I'm not comfortable with"* ***(G: P30/LP22-23)***

While John described the impact of his clients' cognitive distortions on him by explaining how these distortions became significant within the intersubjective space, George described his understanding of the dynamics between himself and his clients in the case of ruptures in their relationship. His understanding is that the threat to his autonomy is generated by what he described as the "dissolution of boundaries" between himself and clients, which is related to the accompanying feeling of a "full sense of madness" with which he admits feeling uncomfortable. The notion of differentiating between self and other, which has been already discussed in previous subthemes, is once again highlighted. However, in this case George talked about his

own difficulties in differentiating, which he understood as an outcome of his excessive engagement with the client. George's experience of 'madness' in sessions is understood as moments where self-experience becomes doubtful because of his felt sense of the dissolution of boundaries and therefore as a disruption of his autonomy. George employed the term "madness", which may give a clue that perhaps in his experience psychosis may be fundamentally linked to the experience of this dissolution of boundaries. This is closely associated to the alienated and incomplete sense of self that was described in earlier themes and perhaps implies that this is what participants might be experiencing parallel to their clients' experiences.

5.2.3.2 Subtheme 2: Disruption of reflective capacities and contradictions

This subtheme deals with participants' accounts of disruptions to their reflective capacities when working with psychosis. This is related to the previous subtheme in the sense that participants' autonomous sense-making capacities seem to be affected at some point in their work. What became evident through all the participants' accounts is that the disruption of their reflectivity appeared as an inescapable phenomenon in their work while for some these difficulties were also manifested during their interviews. In particular, George's and Carla's accounts revealed significant contradictions during their interview in response to these disruptions, and a particular emphasis on their cases will be apparent within this subtheme.

Paula expressed that sometimes it felt almost impossible to make sense of how her client understood their relationship, and that even though she had developed a formulation felt that this was interrupted by the challenges and discontinuity brought up in their work:

> *"Or there was a time when she called me the pixie lady for about a year. I guess, I think this is a very difficult case and sometimes it's almost*

impossible to reflect upon these things", "I mean, I have a formulation, but there is too much there to make sense of. There is too much discontinuity and it's impossible to put the links back again and that she has a coherent sense of self or how I would like her to have" ***(P: P23/L119-120 & P27/L138-139)***

Paula found this client's case so complex that it was difficult to formulate with the breaks in the continuity of the intersubjective experience which made it difficult to formulate the case. She made an implicit connection between her confusion and her client's incoherent sense of self, and her need for a coherent reflective capacity is echoed in her wish for her client's stable sense of self. Along similar lines and in the state of lack of connection to her client, Barbara seemed to find hope important, by holding on to the anticipation that some kind of understanding might emerge in her work with her client, or that there was some kind of explanation and meaning to be found there:

"(...) I can imagine there is emm…a more connected explanation, because this is again something, from, nothing connected so I don't, I, I, don't have an image for (p) you to form an understanding or to feel what's going on, except from the fact that there is nothing to hold on to", "But I don't have a sense of...so, if I don't have a sense, I don't know, I also don't know myself in it. Because I don't have a sense, because I can't put it on her, I can't put it on me. I don't know. So I can't just describe openly what's happening" ***(BA: P67/L329-331 & P81/L404-406)***

It is interesting to observe the usage of particular words in describing the difficulties in making sense, like "connected explanation," and "image" which brings to mind the image of a fragmented puzzle which needs assembling. In these emerging difficulties, there is a further challenge in describing what happens in the moment with Barbara repeating the word "sense" and its lack. In demonstrating his difficulties to reflect and make sense of his involvement during sessions, John demonstrated the importance of distance and time in allowing reflection to emerge. He understood his lack of reflection as related to being "caught up in" an undifferentiated state between himself

and clients, which relates to the previous subtheme and the felt sense of autonomous sense-making processes being violated:

> *"Because well as you know, well sometimes there can be great confusion or loss of boundaries as one of the common features in the more severe psychosis a lot of being unable to differentiate between self and other, (p) and to some extent one might sometimes find oneself doing things and only afterwards realize what was getting caught up into (...)"* ***(J: P14/L90-92)***

Carla and George both demonstrated their difficulties in reflecting on their relationships with clients during sessions with some powerful contradictions evident in their interviews. They both appear to contradict themselves at several points in their interviews, with these contradictions revealing not only how their reflective capacities were affected during sessions but also during their interviews. Their excerpts below contain some rather contradictory experiences and explanations, which may be a further illustration of the difficulties participants experienced with their reflective capacity while working with people with psychosis:

> *"We work together for almost two years now, no, that is wrong; I think a little bit more. Actually almost three years? You see what is happening here already, thinking about this patient makes me block, not thinking as I normally do", "(...) I mean, confusion, do you see what I mean? (p) (...) and there is confusion, when coming closer to him I feel attacked symbolically, my thoughts, and it is very strong. I mean, it is many things together. So I kind of, find it difficult to think properly...", "(...) I want you to come closer. Which is not difficult to me, but yes", "This is the beauty of working relationally. I mean it comes naturally to me, yes, and I don't find it difficult", "(...) you know sometimes it was very difficult to understand what he was saying, I couldn't follow his stories, and I couldn't connect with his emotions (...)"* ***(C: P8/L44-45, P21/L157-160, P20/L153, P20/L149 & P33/L257)***

> *"But I personally don't find that difficult at all", "So my experience is that I can completely make sense of the patient's experience", "So there is an*

example where I got the feeling where this is too horrific. Either I can sit with that or I can't actually say that I can relate to it because I couldn't", "(...) when I actually start feeling that this is going a bit mad and when I actually start to experience a full sense of madness which I'm not comfortable with" ***(G: P3/L44, P5/L56-57, P20/L362-363 & P30/L553)***

In brief, the difficulties in maintaining a reflective capacity appeared closely related to all participants' experiences of ruptures in their therapeutic relationships. The absences in participants' self-reflection seem to parallel clients' self-reflective absences, which were stressed earlier in this chapter and related to issues of self. In the last two subthemes of this section, how participants dealt in response to the challenges of maintaining their reflective capacities and the related ruptures in therapeutic relationships are explored.

5.2.3.3 Subtheme 3: Assuming responsibility

Participants' relational approach and resultant dynamic involvement with clients appeared to have generated an awareness of their own position and constitutive function within the therapeutic relationship. What became evident in the majority of participants' accounts were numerous attempts to assume responsibility for the experiences of disruption in relatedness. Even though the readiness to accept and express responsibility varied from participant to participant, the assumption of responsibility for the majority of them manifested at times through self-critical statements:

"(...) I'll be struggling with my confidence regarding the interventions", "Yes. So I'll be wondering whether I should be working with this person", "I am feeling quite responsible for that really" ***(P: P24/129, P25/L133 & P35/L168)***

"(...) it doesn't give her anything, it has nothing to offer", "(...) but failure; guilt also comes up…again some come or less. I don't know if there is a word for about…to feel unethical, like I am not doing my job" ***(BA: P71/L349 & P75/L379)***

" (...) I think it was, it was totally my issue", "(...) and I think it was completely my issue to carry on pretty much from where we were", "I thought it was my fault" ***(BE: P26/L303, P27/L310 & P34/L356)***
"And there, there is responsibility. Responsibility falls on me", "I'm always asking myself, where has it gone wrong? (...) Or what's the consequence of me having not done this, or said this, on, on, the relationship between us" ***(J: P27/L229-232 & P26/L218)***

"And it felt like it was totally my own fault of what happened, I mean this whole disruption between us", "Oh, it was horrible. I felt very upset, and angry with myself, guilty. That it was my entire fault" ***(C: P13/L87 & P15/L98)***

Overall, as is evident from all the excerpts above, the experience of doubting oneself as a therapist and being self-critical seems to be associated with the participant's tendency to assume responsibility for the therapeutic ruptures and this is another example of how deeply affecting relational failures for therapists are. Moreover, their readiness to accept responsibility seems related to experiences of therapeutic impasses and the anxiety generated by the anticipation of therapeutic change. Someone might assume that participants' assumption of excessive responsibility and their sense of being burdened by stagnations in the space in-between might be mirroring clients' state of helplessness and express participants' difficulties in finding active ways to encourage the assumption of responsibility considering clients' greatly disadvantageous circumstances.

5.2.3.4 Subtheme 4: Compensatory mechanisms

Having already sketched how participants understood their own involvement and processes related to the relational difficulties emerging in the space in-between themselves and clients, the current theme deals with the detected 'manoeuvres' participants seemed to have taken in order to deal with and survive these relational challenges. The subtheme was named "compensatory mechanisms" in an attempt to capture how participants responded in order to compensate the experiences of alienation from their clients. At times this created a frightening confrontation with a sense of groundlessness related to the difficulties. Two key mechanisms were identified: A need to seek structure, at times through the employment of technical and psychiatric language or seeking particular interventions – incongruent with participants' therapeutic approaches – while the second involved participants' sense of specialness and differentiation from their teams and colleagues.

In response to her expressed difficulties in making sense and relating to her client's experiences, Paula adopted psychiatric categories in her discourse, which were very rare in her interview overall:

> *"I think there is a fine line for this particular lady between personality difficulties and psychosis. And, there are times when there is clear psychosis and other times a borderline personality disorder element in terms of her seeking care", "(...) sometimes when I start looking for tools and they might inevitably be CBT related tools, because CBT has a lot of tools, more of the doing interventions I wonder if that relates to a, I guess it's another way for me to sort of structure myself and make sense of what's happening but also possibly sometimes another detachment from the being-with"* ***(P: P23/L119-121 & P61/286-288)***

The employment of psychiatric discourse appears incongruent with Paula's professional identity as a counselling psychologist and as will be evident from a subsequent excerpt in which she differentiated her therapeutic approach and conceptualisation from the rest of her team, which was medically and psychiatrically

oriented. Paula explained how she understood the function of her need to employ specific interventions in the state of feeling detached by her clients. She explained how her need for some kind of structure in moments where meaning-making of the in-between processes seemed difficult was related to her experience of detachment. Paula distinguished between two modes of existing in sessions, the doing and being-with mode, and explained how her doing mode is used against her detachment from clients. In the excerpt below she further demonstrated how she understood her difficulties in ending sessions by expressing her need to focus on something that is more real and less subjective:

> *"I guess it makes me think about that kind of attaching and moving away to a degree. I think there is a way in which I support that in terms of how I ground people and at the end of sessions and focusing on something that is reality based and more real. But I am detaching a bit in that, in sort of ending the encounter"* ***(P: P51/L250-252)***

In this excerpt Paula shed light on her approach and related process during the endings of sessions. What I find interesting in her statement is the employment of the verb "ground" which she related to endings. Her subjective sense of groundlessness resulting from the detachment and difficulties in relating seemed to have generated a need for inviting clients to engage with subject matters that are based on objective grounds. But why was this elucidation referring particularly to the endings? We might assume that her need to 'land' both herself and clients on a stable and safe platform seems to provide a sense of security compared to the experiences of 'turbulence' preceding the ending. However, this process seemed to make Paula detach, perhaps because she adopted an inauthentic stance incongruent to her therapeutic approach, but necessary in order to survive confusions, and to deal with detachment while managing the ending. Similarly to Paula, Barbara's need for engaging with something tangible and structured is informed by her difficulty in meaning making and her sense of aloneness, which is further exemplified through the use of the word *"*substance*"*:

> *"Yeah, yeah. Alone, lost, unclear. It's not even, it's not even, I was kind of thinking failure. But it's not even that. It's before that. It's not even failing*

to do something. Hmm…Yeah and then (p) in a sense it's difficult ethically, because we are suppose to do something. This is the occupation of change. Profession of something…of substance","And I have another one that I am only working for…it's more on the ADHD, borderline area, but we are only working for a month and a half, he is going to be leaving now he will not stay, anyway, very difficult to connect with…", "And she was diagnosed at our unit with paranoid schizophrenia and the other girl is like hardcore borderline and something in that mixture, kind of went through…a layer and it wasn't working. Too many issues yes, borderline and psychosis made the relationship difficult" ***(BA: P72/L359-361, P66/L314-315 & P81/L418-420)***

Barbara described her anxiety regarding the difficulty in connecting with her client, while a sense of being stuck predominated. Her feelings of aloneness and confusion in sessions generated an elated sense of responsibility that in turn resulted in ethical dilemmas about what the work should be like. A perception of therapy's main ambition as being directed towards changing people appeared somewhat at odds with an interrelational approach to therapy. It seems that her state of being stuck with this particular client invited the compensatory tactic of revisiting the perceived objective of the profession, in order to counterbalance confusion and aloneness. Analogously with Paula, Barbara employed psychiatric discourses when she went on to explain the relational difficulties that emerged in her work with the aforesaid clients. Likewise, Barbara seemed to engage with this language only in the cases when she was describing relational difficulties and her experience of being disconnected from clients. Additionally, Beth also employed psychiatric discourse while describing difficulties of a relational nature with her client. Apart from the use of words like "disorder" and "diagnosis" she also employed the word "functional", which connotes with Paula's and Barbara's notions of objectivity and practicality:

"(...) who I had problems connecting with has a diagnosis of bipolar disorder, slash psychosis (…) Because he is actually a quite functional person. Emm…very, very functional. So, emm…he had a lot of difficulties with people he lived with, the less functional. He had issues with

superiority and inferiority, that sort of thing. Narcissistic type difficulties" ***(BE: P23/L210-214)***

Moving on to the exploration of participants' second 'compensatory' approach, evident in John's, Carla's and George's accounts in the following excerpts was their perceived sense of specialness of their therapeutic approach due to an expressed differentiation from other approaches and colleagues:

"I think he realized that what we, me and my colleague were offering him was something different from what he'd experienced before", "…so I think the fact that he (p) rather than other approaches which were trying to sort of get rid of the voices and things like that and so on and suppress them and so on..." ***(J: P21/L145-146 & P21/L147-148)***

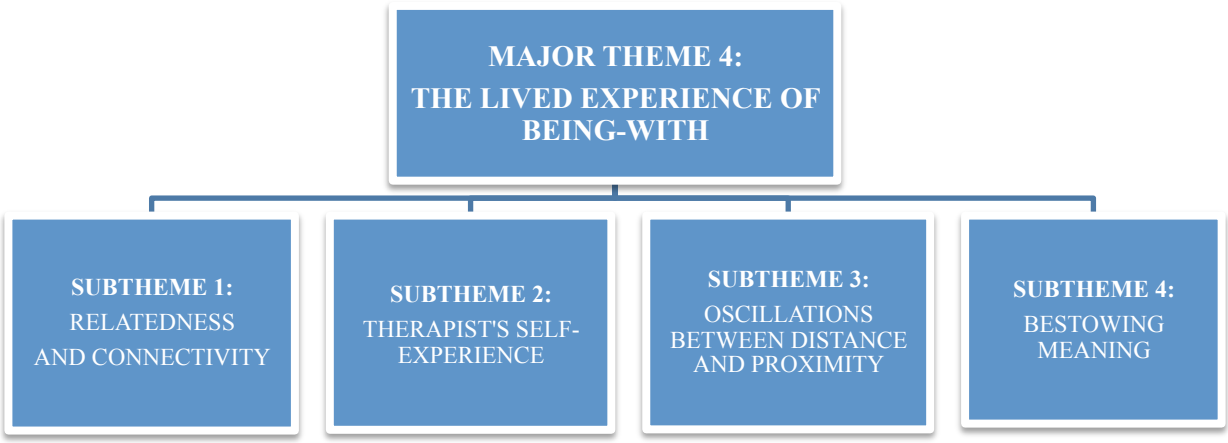
"But again it's very difficult, very few of us work intersubjectively", "And very few of us do this work", "But the other co-workers, are not always ready, I mean I don't blame them. They are not always ready to understand what's going on with, emm…they sometimes raise obstacles, their thinking it's not sensitive to the therapeutic process." ***(C: P35/L290, P36/L294-295 & P35/L285-26)***

"Most people I do think have neurotic defences, which protect them from truly engaging with the reality that nothing is quite real and that life is quite mad if we truly, truly look at it. And few people have the capacity for that", "...and I have worked at an interpersonal level with them that other people would have been mortified by...", "(...) a lot of people would not make this effort to break into their world because either they don't care or they are terrified" ***(G: P6/L82-84, P9/L128-129 & P25/L456-457)***

Overall, it seems that all participants' expressed sense of specialness and differentiation is introduced while discussing the relational challenges experienced in their work by considering themselves as part of a minority group of people who work intersubjectively with psychosis. My assumption is that their need to maintain some

of their sense of self-importance and communicate that their work has some deep significance are closely associated with the experienced relational challenges in their work. In other words, the generation of a sense of specialness seems to accommodate the sense of a relational failure, in order to make it tolerable and assist the survival of therapists' roles under challenging relational circumstances.

5.2.4 Major theme 4: The lived experience of being-with



The last major theme was named "The lived experience of being-with" and was inspired by Paula who explicitly employed the term '*being-with*' several times during her interview. The current theme captures the depth of participants' deeply affecting experiences while attuning to their clients' lived experiences and worldviews. While in previous themes participants' descriptions of their clients' interpersonal difficulties have been portrayed, in the current theme their descriptions of their clients' capacity for interpersonal dialogue are also presented. Moreover, while participants have demonstrated the dynamics of distance and relation, the function of distance and disconnection for participants will be stressed. This theme also captures participants' demonstrations of how their sense of self underwent several transformations during sessions and how it was inextricably linked to their encounters with clients. Lastly, despite participants' struggles to reflect and make sense of their own and clients' experiences that have already been described, this

theme shows how their sense of connectedness and attunement to clients was experienced as the generator of meaning.

5.2.4.1 Subtheme 1: Relatedness and connectivity

The first subtheme deals with participants' sense of reciprocal connectedness to clients and how these experiences manifested during sessions. Moreover, participants' subjective understanding of how connectedness affected the overall therapeutic relationship and outcome is addressed.

In reflecting about her experience of connectedness with clients and how it manifested within sessions, Paula expressed her openness through the emergence of humour in her encounters with clients:

> *"(...) sometimes with humour, or sometimes it can actually come out of the discussions with them, it comes out of the more human relationship, rather than me trying to employ a diary for them if I am using a CBT intervention. And I guess that brings me back to the difference between being and doing and being aware of that. And being-with allows forming the relationship (...)", "I guess I am more present emotionally in terms of acknowledging the whole person, not just the psychosis so we might not be talking about that. With that I am more present within myself, I bring more of myself to that"* ***(P: P39/L186-189, P40/L191-192)***

In comparing moments of connectedness to those when she felt less engaged, she ascribed humanness to the relationship ("being"). This was contrasted to those moments she felt inclined to deliver specific interventions ("doing"). Paula clearly explained how the experience of being-with was a precondition for the development of a therapeutic relationship. She demonstrated that when she felt connected to clients she was more emotionally present which resulted in an acknowledgment of the wholeness of her clients' experiences. Her description implied a deep involvement while her emotional availability, which enabled her to draw on her own experience,

and this in turn facilitated the relationship. Cherishing the wholeness of the human being and the client's experiences beyond their distress accompanied her willingness to bring more of herself to the encounter, with the dialogue concerned with matters beyond psychosis. Along similar lines, Barbara and Beth stressed the importance of connectedness and reciprocity in their work:

> *"It happens naturally and today you know when we were going towards the end of therapy he knows exactly how I feel towards him.", "(...) we have a very strong relationship (...) but there is this lacuna, this area that we don't enter. And that possibly is you know, a deeper level of connectivity. It's not that it doesn't exist. It's not that there is nothing to hold on to", "You know, to see the potential I think that's what connects me to clients, some kind of potential that you can connect with them, have a bigger space in them", "(...) I think we'll be able to pass through it because, because it's somewhere that we need, so that we can get connected with this lack", "(...) and I think if I would think hard I can find the places where he was there for me. But I think that's very important", "Well, I think I get something from it also. They become meaningful, for this connectivity they become significant. So it's a good place"* ***(BA: P32/L128, P82/L424-426, P37/L159 & P81/L409)***

Apart from Barbara's semantics, her quiet tone of voice and faintly amused gaze throughout her description communicated and made evident that her relationship with this particular client meant a great deal to her. The sadness related to their ending, which was intensely communicated through her eyes, coloured her description throughout. Her openness and emotional transparency to the client not only highlighted her relational approach but also demonstrated the importance of connectivity throughout her work. At a later stage, Barbara described her connectedness with another client through the introduction of the word "lacuna" which I consider interesting in the passage. On the one hand it communicates a sense of risk inherent in the space in-between in the sense that it embodies a potential for further connection which Barbara finds challenging, and simultaneously it is the space that separates Barbara from her client. In other words, it is the space which separates and

unites. Regardless of how the word "lacuna" is used from either the angle of linguistics, music or manuscripts, signifying a lexical gap, a missing section of a text, or an extended silence in a piece of music, it is generally considered as an inextricable part of the whole. Similarly for Barbara, this lacuna or lack in the in-between, seems to represent an inextricable part of her relationship with her client which embodies an opportunity.

The expressed experience of reciprocity and experience of connectivity and meaningfulness was also stressed by Beth:

> *"But we had a lot of moments where I felt that we were connecting if you want to call an I-Thou relationship. The, I don't know if I can describe it completely", "Sorry perhaps I'm going too much into it. But I was extremely connected to him and by using myself I think slightly too much I became I sort of followed the vulnerable child a bit too much, and he was actually very helpful, he kind of realised that not in these exact words we were able to sort of organise that together. So he would, yes. Anyway I don't want to go too much into it. He helped me and I helped him", "Actually, talking about him I have a physical reaction, my stomach is hurting. And I'm imagining that probably at the time of, having that physical reaction, I certainly would have tears in my eyes, and yes, and normally when I feel emotional I also have pain in my stomach", "A lot of sadness it was very overwhelming, he was somebody I got very attached with, and it was very sad when he left"* ***(BE: P30/L322, P40/L428-430 P33/L340-343 & P34/L352)***

The powerfulness of the experience of attunement and connectivity to her client finds expression in Buber's proposition of I-Thou with a sense of mutual support during sessions. She highlighted her connectedness to her client by stressing how her excessive use of self was regulated through her client's support. Despite the spirit of cooperativeness communicated, Beth also hesitated to proceed in further exploration of her relationship with this client. It felt like she was setting a boundary in terms of how much she was willing to disclose. The "perhaps I'm going too much",

"I don't want to go too much into it" and the firm "he helped me and I helped him" communicated a hesitation to further delve into the relationship with a need to protect something. Perhaps Beth's wariness during the interview to explore how this client affected her found a way to channel through an embodied response. Something very powerful that could not be silenced or 'ingested' easily made its way through Beth's stomach and signified not only her deep connectedness to the client and sadness which came with ending but also communicated that her attunement to the client's experiences allowed access to something personal and painful. Her bodily responsivity at the time of the interview, therefore provided an indication of how both her body, cognitive and affective states were all participating in the formation and maintenance of interpersonal understanding. Moreover, Carla and George also shared the reciprocal nature of their therapeutic relationships which is demonstrated in the excerpts below:

> *"(...) our relationship is able to contain me. Not only me, both of us, but I am talking about me here so, yes", "How can a disturbed person, and sorry, I am saying disturbed only because I can also speak of my own disturbances, yes…I mean it is not label or, you know, we all are to different degrees. So how can disturbed people hold me emotionally?", "I often look forward for our session, it is so easy now to follow him, emm and also, he knows that, he feels that, yes, he tells me that sometimes. I get so many things as well, from him (p) he seems to, he holds for me, and not only him, he holds parts of me, if you prefer, contains some of the craziness that you don't get with other patients (...) it is a very strong connection, I feel for him, emm…I mean I care for him a lot, we have a space, we created a space, which is very safe for both of us"* ***(C: P9/L53-55, P10/L63-65 & P34/L266-270)***

By referring to the experience of feeling contained by her client, Carla made a comment about her understanding of how the client had contributed to the containment of their relationship overall. Even though this partly implied how she understood both herself and the client as equal partners in their relationship, her acknowledged experience of unpredictability and expression of surprise, also communicated a sense

of decenteredness. Carla's intense involvement and emotional transparency brought her vulnerability to the fore, and the client's containment perhaps decentred her perception of power dynamics. Therefore, despite her commitment to a relational approach and mutuality, the lived experience of being contained destabilised her perceived therapist role. Also, the experience of connectedness and mutuality is demonstrated by explaining how connectivity and reciprocity have assisted the development of a safe and dynamic space that generated meaningfulness.

Additionally, George also expressed the experience of mutuality and reciprocity by explaining how both parts of the relationship were offering something significant, and how his clients contained his madness:

> *"…as much as I contain sanity for that patient that they can't hold, they could hold my madness because that's their base position", "I find these people much more real and they contain a part of me that these people cannot contain. And there is the sadness. I feel left afterwards, I feel lost with that. Because I certainly think as I said earlier on, the world is mad. The experience of life is mad", "(…) if he was a private patient and if I was to get paid for it, I'd happily see him twice a week for the rest of my life. He fascinates me. He's funny when he's okay, tremendously funny. Because he sees so many things in the world that other people don't see, more nuances that I find funny", "Often working with psychotic patients, they can open up a world for me, which I often find fascinating and I can see it with them, and yes, I lose that. And I do find that very, very sad. So it is not just them, there is certainly a part of me that does find that sad but unfortunately is part of the profession"* ***(G: P27/L506, P28/L512-514, P25/L463-465 & P26/L492-494)***

George's connectedness to clients provided him with an opportunity to rest his anxieties on his clients' worldviews. His connectedness to a client who has already been discussed in a previous subtheme is described above through a longing for a life-long collaboration. George described the relationship as a fascinating learning journey for him while he particularly stressed the impact and meaningfulness of his client's

worldviews. George's sadness for what gets lost on a personal level is passionately portrayed.

Overall, all participants have revealed very powerful issues relating to the balancing of the therapeutic relationship. They all seem to be aware that the relationship is crucial and they are surprised by how connected they feel with their clients. By allowing their clients to connect with them in a human congruent way, they are perhaps providing something helpful to the client that is perhaps different to people who present with non-psychosis difficulties. This subtheme has described how crucial it is to use the relationship as a key therapeutic modality in people with psychosis. By really coming close to the person in a genuine way it also involves giving a bit of the participant's self to the client, which at times seems to be experienced as a terrifying experience.

5.2.4.2 Subtheme 2: Therapist's self-experience

Despite participants' experiences of cognitive and emotional destabilisations as an outcome of intense relational work with psychosis, the exploration of their experiences in attuning and connecting to their clients' experiences and worldviews disclosed that their dialectical relationships revealed aspects of self-perception and in some cases generated a sense of self-transformation. Some participants implied through their examples the experience of having their clients emerge on the horizon of their self-experience, which proved that the way they experienced themselves predicted the way they experienced their clients. Even in cases where participants' self-experience encompassed moments of disembodiment and disruptions in the fluidity of their affective experiences (as in the cases of Paula and Carla), it also demonstrated that their sense of self was inextricably linked to the encounters with clients and their otherness. The current subtheme deals with an extension of these processes by demonstrating how therapeutic relationships of mutual regard, assisted the majority of participants to revisit their sense of self in the process of recognising and valuing their clients' otherness. In the following excerpts participants have

demonstrated how the space in-between provided an opportunity for connecting with and revisiting their own sense of self:

> *"I guess it comes up with just the acceptance of things. Much more existential level really. You know really difficult things happen in life and I suppose with that probably my awareness that difficult things happen in my life as well and how do I deal with that. And about being more grounded in that and I think the warmth is also from the position of the awareness of myself and from my own experiences of [P] if that makes sense really", "And in the rest of my working life I am not religious as a person necessarily (…) I sort of resist to that but in my client work I accept it and see that it has value for people but it forces me really to question my own beliefs. If I'm truly present with someone it challenges me"* ***(P: P43/L203-205 & P45/L214-216)***

The description of Paula's experience demonstrated how the space in-between constituted a space through which a dynamic identification with the client's experiences was made possible. This provided an opportunity for Paula to connect with aspects of her own lived experiences and life difficulties and how these have deeply affected her. An acknowledgement of her client's difficulties that were earlier understood as lacking meaning were here revisited, and understood as embedded with meaning. Paula's self-awareness went through a transformation and given the opportunity to sit with her client's facticity became able to sit with her own facticity too. Her existential awareness that was brought to the fore through this experience was also related to how warmth and acceptance towards her client and herself were generated. Paula further explained how in the state of being "truly present" with clients and confronted with their otherness – which involved the awareness of her own flow of experience and the acknowledgement of clients' experiences – she felt challenged to revisit her own stance towards social, cultural and spiritual issues. In other words, clients' otherness according to Paula provided her with the opportunity to revisit her own worldviews despite the challenges that came about along the process.

In describing the difficulties to enter the "lacuna" space in her work with a client that has been discussed earlier, Barbara also explained how these were associated with an anticipation of connecting with her own issues while Beth demonstrated her sense of appreciation related to the experience of mutual connectedness:

> *"Like a simpler aspect would be my issues. So why I went to become a psychologist, that my, my struggles in psychology (...) And I guess it is, it's like an echo of being rejected, or hurt, and being tempted to do something that doesn't fulfill itself. It's that, that area. That's the place that I can possibly connect with"* ***(BA: P84/L430-433)***

> *"So I actually liked that, I liked that I was connected, for them and also for me, for me, as a person, I had difficulty my life, I wasn't connected with my emotions and I didn't learn to do it, I avoided them for a long time so it is something that I learned and I liked", "(...) I think it's quite important, I feel I can relate to these people. To some extent. And I feel very, so I connect with myself, with what I am and also I find it intellectually quite interesting. But more on an experiential level"* ***(BE: P33/L343-344 & P49/L494-496)***

Barbara went on to describe particular challenges like her struggles with the profession and her perceived identity as a psychologist. Her hesitation to enter a space of further mutuality and connectedness seems to have provided access to her self-awareness and the anticipation of being rejected or hurt by her client. The intensity of her self-experience appears therefore related to the experience of being confronted with a possibility of further connection. Additionally, Beth's experience of connectedness to her client provided her with the opportunity to revisit a past sense of self that she described as unable to connect with her emotions. The ability to attune with her own emotions by connecting to clients' experiences was celebrated, and her current sense of self was inseparably connected to her encounter with clients. This was illustrated when she described how her ability to identify and relate with clients allowed access to her sense of being.

Lastly, both Carla and George also shared very clearly how the experience of connectedness and being-with their clients provided the space for self-awareness, self-reflection and self-transformation:

> *"I really felt his pain, and mine. I was going through a very stressful period on a personal level at the time", "You know, I felt that I suddenly became something I wasn't aware of before, like I, I, but that I also wasn't aware of. Something that terrified me. Yes, I did feel terrified. Also, because, you know, because of the experience of not knowing who I was in that moment, but also because of coming closer to a part of myself which was scary", "(...) I mean coming closer to him, meant that I was becoming closer to parts of myself that I didn't know existed to a certain, yes, to a certain extent. What comes to mind now is issues around identity and sense of self. This patient's unstable sense of self threatened me but not only, I mean (p), it also enlightened something, to a certain extent, very existential about my sense of self in many ways. I mean my identities or roles let's say, as a therapist, as a mother, as a daughter etc and how they are connected or not"* ***(C: P13/L84-85, P16/L105-107 & P18/L124-128)***

> *"(...) things got under my skin where I couldn't step out of because I encountered a level of terror, that I had, or despair, that I had previously not found in myself. So either I took on the person's despair or because I allowed myself to connect, I found a level of despair in myself that I previously not been aware of. And it was scary. That sometimes happens. But that I can only call it the very depths of despair. Where everything is lost for example and one has a snapshot moment whereby you realize you can't hang on to anything in life truly"* ***(G: P20/L353-356)***

Carla described her affective state while connecting to her client's difficulties and explained how her compassion towards her client was associated with the awareness of her own personal struggles at the time. Moreover, a deeply felt communion between Carla and her client was illustrated, through which the identifications with the client appeared to have generated an intense and terrifying

self-experience although she was able to experience her self as differentiated. Her self-awareness in the passages above was related to the reflections on her awareness of the awareness of the client. The recognition of her own vulnerable parts allowed a further formation of a bond between her and the client and the dialogic connectedness became the vehicle for exploring unknown and terrifying aspects of herself. The illumination of these 'untrodden' territories of self was therefore embedded within the relational space between Carla and her client and the intensity of her self-experience was related to the intensity of her confrontation with the client's otherness. Carla's existential awareness of issues around identity and sense of self were exemplified and the client's unstable sense of self seemed to have allowed access to her multiple self-positions, their congruence and connection and also their disparity. George also demonstrated the frightening experience of transformations in his sense of self. His experience of being strongly affected through his connectedness to the client, and the inescapable encounter with the terrifying despair that he found himself consumed with, was portrayed in the expression "things got under my skin". George's modification of his sense of self became a terrifying experience as it communicated a sense of petrifying helplessness and immobilizing vulnerability, which he vividly described as the very "depths of despair".

5.2.4.3 Subtheme 3: Oscillations between distance and proximity

Carla and George both inspired the title of the current subtheme since they both explicitly discussed the notions of "distance" and "proximity" during their interviews. Moreover, all participants in their own unique ways and through several examples shared their experiences and understandings regarding the altering moments between distance/separation and relatedness/confrontation. Some participants mentioned how in moments of subjective threat, reflectivity was made possible only when they maintained a distance from clients. More specifically, they shared that when their reality or autonomy felt threatened, they tended to erect a wall in the space in-between. Additionally, participants' oscillations between distance and proximity appeared to generate rapid affective and cognitive changes with accompanied

transformations of their sense of self – as has been already explored in the previous subtheme. Participants' experiences of oscillations brought to the fore the possible function of maintaining a distance, by maintaining their distinctiveness from clients especially in moments where their autonomy was shaken, or when they felt a merging or colluding with clients.

Paula in this passage below expressed how she understood the function of the employment of cognitive-behavioural interventions in her work with a client who shared intense fantasies:

> *"(...) and I think sometimes when I start looking for tools and they might inevitably be CBT related tools, because CBT has a lot of tools, more of the doing interventions I wonder if that relates to a, I guess it's another way for me to sort of structure myself and make sense of what's happening but also possibly sometimes another detachment from the being-with. And I guess that's quite interesting if we are reflecting on it in that way. Often it seems very natural and perhaps it's a useful thing to do and bring some of that to my work. But I think it's also helpful to reflect on it really"* ***(P: P61/L286-290)***

By making use of CBT interventions she felt able to 'protect' herself from those moments of being-with that she could no longer sustain. These interventions provided Paula with the opportunity to contain her detachment from the space in-between by also allowing the formation of helpful reflections regarding the in-between processes. Moving from the being-with to the doing mode was therefore understood as an essential dynamic of her therapeutic work with psychosis. The phrase "structuring myself" employed by Paula signified the awareness of an unstable sense of self in the mode of being-with. With a sense of self being perceived as lacking structure and stability, the enrichment of her therapeutic position with further tool-related interventions assisted the rendering of a stable sense of self, otherwise subject to uncertainty. In exploring their relationships with particular clients Barbara, Beth and Carla expressed their need to pull back from the work. In the passage below, Barbara demonstrated the naturalness of this process:

"(...) we started with a lot of mistrust and then he settled well into my world, you know I liked him, he has good aspects but he can throw me out at any time. But the same can happen with me. In and out, but see it's part of the process, the relationship" ***(BA: P27/L107-109)***

While Barbara expressed how she had experienced her client's unpredictable disengagement from their relationship, she also shared how this was held true for her as well. She went on to talk about how the "in and out" manifestations were understood as an inescapable part of the therapeutic process and relationship. In reflecting on the endorsement of a second-person perspective approach against her client's paranoid thoughts, Beth also shared that a need to disengage from the relationship emerged and was related to her own need for reflection and disentanglement from the in-between processes:

"And, the main work I did was reflecting and bringing myself fully into what was happening. He would be like "oh so you're thinking this, and you must be thinking that" so very paranoid, a lot of paranoid thoughts. And I would go back, and sit with myself, and I need my space to think and understand" ***(BE: P39/L395-397)***

Along similar lines, Carla described how the emergent need for emotional and physical proximity to her client and resultant responses generated an emotional conflict in her:

"I really felt his pain, and mine. I was going through a very stressful period on a personal level at the time. So he didn't say anything, and I didn't, I just left and when I entered my office I felt so ashamed I did that. (...) I couldn't breathe for a while. So yes, it was so strong, and then when he, when he (P) when he came for the next session I was very passive, I didn't allow him to..well…it was strange, I felt guarded" ***(C: P13/L84-86)***

She described feeling ashamed for having touched her client on the shoulder to communicate her compassion and acknowledgement towards his difficulties. Her

deeply felt connection to the client overwhelmed her affective state with related embodied responses emerging and with her breathing difficulties communicating the entangled affective response. But what might such a powerful affective and embodied response to her emotional proximity to the client have entailed? Her panicked body and breathing difficulties manifested as a response to an interpretation of a threat that was also felt during the next session, which produced a need for self-protectiveness. Carla shed light on the nature of this threat in the following passage:

> *"So, but also because before I was talking about how important it is to find the good balance between distance and proximity, generally with all kind of, you know clients but in psychosis it becomes very important, more important. Yes, so part of this distance, which is very important as well because the client also needs help to understand that is separated from you But no, not just the client, me as well. If I don't move back it feels like I'll get swallowed."* ***(C: P19/L136-138)***

Carla stressed how the importance of finding a good balance between proximity and distance prevailed in her work with psychosis. The function of this distance was concentrated on the differentiation between Carla and her clients, while a fear of the possibility of being "swallowed" by clients was declared. Carla's previously discussed sense of threat seemed related to her sense of autonomy being threatened. The need to pull back assisted the development of autonomy and separation. Similarly with Carla, George explicitly demonstrated the importance of paying close attention to how he and his clients negotiated proximity in the space in-between in the excerpt below. He explained how he existentially understood his efforts to drag clients out of their isolation and what this process entailed. He stressed, that the right amount of distance and proximity must be estimated and negotiated according to both the clients' and his own capacities for confrontation, otherwise both might end up feeling overwhelmed and the relationship might disintegrate:

> *"So how close I can come, or how far away I need to be is exactly what I need to work with. Because again there again, in an existential sense all I'm trying to do with a psychotic patient is to drag them out of isolation.*

And in order to drag them out of isolation I need to find the right distance. Not too close, not too far, to allow them to safely make a connection with me. If I'm too far away, they will not reach me, I will not reach them. If I go too close, they'll get overwhelmed or I'll get overwhelmed or we get messed up and it collapses. So the whole, and this is generally for me in therapy, the whole game or dance is about the negotiation of the perfect proximity" ***(G: P29/L527-531)***

Overall, all the participants reflected on the processes related to their need for separation from clients during sessions. The majority of them explained how the disruption of boundaries in the space in-between generated uncomfortable feelings in them and described the importance of considering how one moves in and out of the edges of the therapeutic boundaries in an effort to make sense of what lies in the space in-between. Participants needing to differentiate and distance themselves seemed informed by a deeply felt communion and symbiosis, with resultant difficulties in untangling what belongs to whom. This is clearly demonstrated in George's and John's accounts below:

"I'm very up-close with people, I'm very touchy. That doesn't bother me. It starts to bother me when I sense that there is a complete disillusion of boundaries, and when I actually start feeling that this is going a bit mad and when I actually start to experience a full sense of madness which I'm not comfortable with. And that usually feels, happens when I feel I have lost all differentiation and I no longer know where is me, where is them" ***(G: P30/L551-554)***

"(...) which gives you that certain amount of freedom to move, and once you got to that edge you stop yourself and you might be moved towards that edge and then to have just enough space before you go too far to rethink what's going on" ***(J: P14/L93-95)***

5.2.4.4 Subtheme 4: Bestowing meaning

All participants understood their clients' delusions and hallucinations as meaning-bestowing processes. The final subtheme emphasises how participants understood meaningfulness as been established in the space in-between and as an inextricable part of their connectedness to clients. The unlocking of meaning in the space in-between participants and clients assisted the facilitation of self-reflection for both interlocutors, and also reflection concerning the relational processes. Even though the decipherability of direct or indirect intersubjective meaning was not based upon a particular principle for exegesis, the principal condition according to participants pertained the sense of connection amongst themselves and clients. The role of inter-affective relatedness in understanding clients' circumstances and experiences in interpersonal understanding is stressed, with meaning found embedded within the context of the therapeutic relationship that served as a relational home for both participants' and their clients' vulnerabilities.

When Paula was invited to further explore how she understood her relationship with clients in the state of being-with, she explained that the relationship was experienced as more real and with less battle for meaning:

> *"Much more real. Less of a battle. I guess there is less of a battle for meaning really. I suppose is the difference there between trying to sort of either dissect or change meaning from a sort of CBT perspective. Working with beliefs or questioning delusions or whatever might be. To just being-with, hearing how they make sense, how the client makes sense of things. But often I think if someone's not ready to question or to change meaning they would have got it out in the first place. But again if they might be questioning meaning then this brings us more back to the relationship. So being present there and observing it. And this allows them to be present, I see that they feel not judged and more accepted and feel warmth in the relationship. Humanistic stuff", "(...) which enables them to deal with things in the here and now and to help them deal with some aspects of psychosis rather than to battle with it"* ***(P: P42/L197-201 & P13/L61-62)***

The use of the word "battle" exemplifies the sense of protracted polemic involved in the process of challenging clients' worldviews and belief systems. With the anticipation of emergent meaning as the possible prize gained from this battle collapsing, Paula explained how meaning was instead accentuated when she was more attuned to her clients' experiences and provided them the appropriate space to construct the meaning they wanted in the space in-between. Meaning was therefore understood as an outcome of relational processes and more particularly through Paula's validation and acknowledgment of her clients' otherness. Beth also explained her understanding of a close association between the emergence of meaningfulness and the sense of strong rapport in describing the difficulties regarding the comprehensibility of her client's experiences and resultant therapeutic rupture. She elucidated how the therapeutic relationship represented a space within which meaning was redefined and established for both herself and the client while she declared how her anxiety concerning the emergent rupture was contained by the space in-between:

> *"And other things which did not make any sense to me, but if the relationship wasn't strong, I mean, I wouldn't be able to return, and make sense, and the same applied for him as well. All I'm trying to say is that I was very anxious but our strong relationship allowed meaning and survived the rupture"* ***(BE: P26/L303-305)***

Along similar lines, Carla described how her client's delusions were understood and contextualised within their relationship with meaningfulness understood as an outcome of relatedness:

> *"But yes, with this patient the connection is strong, and it is important because, this is exactly why, I mean it is why we are able to understand his delusions, that why they are meaningful", "And one of the things that I kept reflecting about while I was talking to you, is how powerful it is for me as the therapist to be able to construct meaning with the client. And for me the only authentic way to do that is when the relationship is put on the spot, in, yes in the sense that we are connecting and disconnecting yes, but*

that it's part of the relationship. That safe space which is co-created is the cave where meaning is located" ***(C: P34/L276-278 & P36/L295-298)***

When Carla was invited at the end of her interview to make some possible final remarks or to add anything that was of personal importance in her therapeutic work with psychosis, she expressed that throughout the interview she kept reflecting about the powerfulness of the experience of co-construction of meaning with her clients. She pointed towards the acknowledgement of an authentic way of working that comprised the prioritisation of the therapeutic relationship despite the constant oscillations between connection and disconnection that were thought of as integral parts of the encounter. Carla's metaphor of the therapeutic relationship as the "cave" where meaning finds its home, demonstrated how the '*we*' of a mutual psychotherapeutic enquiry facilitated the co-construction of meaning within a space which invited exploration and collaboration. The intersubjective construction of meaning is also illustrated in George's excerpt below. He explains that making sense of his client's experiences in relational terms in turn provided meaning for both himself and the client:

"But the whole point I'm trying to make here it is about something, it's something about finding meaning in these things and understanding them intersubjectively. So for him the fantasy of a bottle that explodes was something that he brought in to test how far or close he can get to me, whether I could manage his madness, his anxiety and so on. And from there on he did that for 3 to 4 sessions and it was not an issue after, it stopped","So if you truly allow yourself to immerse yourself into the narrative of someone with an inner psychotic episode, what you come out with is the experience of how they are relating to the world, or how they are situated in the world, how free or not free they feel there, and it's always internally coherent", "So every meaning that develops, every emotion that develops, develops from relationality or relatedness in that matter. Thereby we can only understand it and work with it in that domain" ***(G: P15/L247-252)***

George's validation of his client's need to blow up the therapy room through the hypothesised explosives contained within a bottle of water decoded the symbolic relevance of this desire. George explained how the decipherability of this symbolism related to the relational processes in the space in-between and provided the opportunity for accessing the intersubjective meaning of the client's fantasy. Therefore, interpersonal understanding emerged through George's connectedness to his client, with the meaningfulness of this fantasy being embedded within the therapeutic relationship. George explained how his dedicated immersion in his clients' narratives resulted in a deeper existential understanding of their situatedness in the world and their sense of freedom. He specified that the development of meaning was contingent upon the quality and depth of the therapeutic relationship, while meaning-building was understood to be possible only through the platform of relatedness. In discussing his experience of intense feelings of shame and humiliation in his work with a client, John also explained how the emergence of meaningfulness in the space in-between was closely related to his connectedness towards the client:

> *"(...) in this case was such a powerful feeling and that's why I put it together and it told me something about the patient. Suddenly it made me feel much more close to the patient (...) But here, this was something that lasted for weeks and months and opened the door to many other… (p). A much richer understanding of psychosis actually", "So it's a question of just gradually making a psychological story that is useful to (...) This makes sense in terms of his life and very…not just intellectually, way of understanding, but that the understanding was highly relevant to his real life issues. But also it makes sense through our relationship"* ***(J: P19/L131-133 & P22/L187-189)***

5.3 SYNOPSIS

In this chapter, the four master themes and constituent fifteen sub-themes were explored, and exemplified through close analysis of participants' experiences. As it became evident in the analysis of findings, despite the optimistic attitude expressed by all participants towards their clients, it was evident that the experience of working with psychotic difficulties left participants feeling deeply affected. Their lived experiences and reflections revealed powerful considerations and implications for clinical practice that will be explored in the following and last chapter of this project. It is also noticed that the presentation and interpretation of findings are not exhaustive and I clearly consider that a different researcher might have concentrated on different areas of participants' experiences.

CHAPTER 6: DISCUSSION

6.1 INTRODUCTION

In this chapter, the developed major themes and subthemes will be considered and evaluated within the context of the existing literature. Each of the master themes will be therefore presented and discussed in light of the existing literature in the field of psychotherapy for psychosis, including theoretical considerations mainly from an E-P perspective, which has been the epistemological and ontological position of the project. Some reflective and critical methodological considerations will be also addressed and recommendations for further research in the fields of counselling psychology and psychotherapy will be discussed.

6.2 DISCUSSING THE MAIN THEMES

6.2.1 The primacy of sense-making

The analysis revealed that all participants often discussed the primacy of sense-making (attaching meaning to clients' experiences and focusing on comprehensibility) and perceived it as a vital and challenging part of their work with psychosis. Despite the challenges that surfaced in participants' efforts to ascribe meaning to their clients' experiences (reflectivity difficulties, ruptures in relatedness, transformations of sense-of-self, rapid cognitive and affective shifts), in the course of therapy these were approached in comprehensible terms and were thought of as carrying some significant psychological value. Participants, therefore, approached their clients' experiences not as problematic 'symptoms' but as meaningful responses towards their deeper crises. Along these lines, Rosenfeld (1987), who worked extensively with psychosis from a psychoanalytic perspective, suggested that even the most 'disturbed' phenomenon, if approached carefully, could communicate something meaningful to the therapist. As Laing (1965, p. 15) has also noted: "(…) the mad

things done and said by the schizophrenic will remain essentially a closed book if one does not understand their existential context". In contrast to this approach, the application of dominant operationalised classifications such as the DSM implies that the practitioner attaches less importance to the person's subjective experience and suggests the non-comprehensibility of hallucinatory and delusional experiences. This Jasperian attitude of ascribing non-comprehensibility to psychotic experiences seems to have dominated traditional and contemporary psychiatry. It is important to note that although Jaspers (1959/1963, 1912/1968) described psychosis mainly as an incomprehensible state that should be treated psychiatrically and not psychologically or psychotherapeutically, he also placed great emphasis on the subjective experiences of people diagnosed with psychosis and strongly suggested that psychiatric symptoms should be approached with empathy. He offered a sound philosophical and phenomenological interpretation to psychiatry's theoretical and clinical elements and approached psychosis as a process which affects the totality of the human being.

In opposition to the mainstream psychiatric approaches' emphasis towards this non-comprehensibility, diverse clinical and research authors from the psychoanalytic (e.g. Fromm-Reichmann, 1954; Sullivan, 1962; Searles, 1965) the humanistic (e.g. Rogers, Gendlin, Kiesler & Truax, 1967) and the existential/phenomenological (e.g. Binswanger, 1963/1993; Boss, 1963; Blankenburg; 1980; Parnas, Nordgaard & Varga, 2010) approaches have all strongly and systematically supported the comprehensibility and meaningfulness of psychotic phenomena. The psychotherapeutic experience of working with psychosis has shown that what initially might present itself as incomprehensible, in the course of therapy and with patience gradually becomes clearer. Indeed, Barbara, John and Beth stressed the function and meaningfulness they ascribed to delusions and hallucinations by particularly considering them as narrations of their clients' life stories. George's emphasis on the co-construction of meaning and his experience of his clients' ability to uncover meaning from their experiences are in line with evidence in the literature, which suggests that auditory hallucinations and delusions are meaningful or insightful to the people experiencing them (e.g. Bentall, 1993; Dorman, 2003). Participants' exemplification that a common communicative platform between them and clients assisted the process of recovering understandability – described as a key facet in

assisting clients to overcome their alienation – has been also stressed by recent phenomenological literature (e.g. Holma & Aaltonen, 2004; Seikkula et al., 2006). Moreover, early existential approaches to psychotic phenomena such as the Daseinanalytic method of Boss (1963, 1979) emphasised that our effort to understand the fact that a person is able to hallucinate under certain circumstances is associated with an awareness of the preliminary nature of our reflections. Boss (1963) attributed a transcendental quality to hallucinations and defined them as "…a de-construction, a disclosing of ways of discovering phenomena and of relating to them which are completely covered up in the waking state of an average existence" (p. 229). Along similar lines, Du Plock (1995) suggested that a person's hallucinations should be taken very seriously and one should acknowledge these experiences as experientially valid. He prompts therapists to examine how these hallucinations fit into the wider map of existence by stressing how they can provide the route to great insight into the person's difficulties and towards recovery. It is also important to add that new promising developments in the field of neuropsychiatry, that link phenomenology with neuropsychological models, point towards the development of models that are based on common cognitive processes and therefore increase the 'understandability' of psychotic experiences. For instance, a recent theoretical paper by Kendler and Campbell (2014) argues that dysfunctional brain processes in psychosis should be apprehended from the angle of neuropsychological models to 'translate' brain dysfunction into the mental. Despite the clear distinctions made between functional/dysfunctional, healthy/pathological states which are challenged from a phenomenological perspective, these approaches contribute towards an empathic understanding of the subjective experiences of psychosis and therefore cultivate a new climate in the realms of contemporary psychiatry by pointing towards the possibility of understandability and recovery.

Recovery in psychosis is progressively conceptualised on an international level as encompassing positive transformations in how people reflect about and experience themselves as individual human beings in the world (Silverstein & Bellack, 2008) and has been associated with an approach to therapy that values the importance of encouraging comprehensibility. In a recent quantitative study by Klaphecka, Lincolnb and Bock (2014), the researchers assessed and compared the

meaning of psychosis as perceived by clients, their relatives and clinicians and explored factors related to inconsistencies between them. These results indicated that despite the fact that relatives and clinicians tended to have a less optimistic view of long-term effects compared to clients, overall participants demonstrated that making sense of psychosis supported insight and recovery. Moreover, a strong agreement was found among clients, their relatives and clinicians regarding a relatively positive, meaningful picture of psychosis. These results add to a growing number of qualitative and quantitative studies which suggest that a meaning-guided approach to the therapy of psychosis, characterised by the development of insight in both therapists and clients, has been related to better outcomes, while it points towards the possibility of recovery (e.g. Bock et al., 2010; Cavelti et al., 2012; Hasson-Ohayon et al., 2009; Lincoln, Lullmann & Rief, 2007; Lysaker, Yanos & Roe, 2009). Additionally, recent work has also emphasised the therapist's role in supporting clients to approach their experiences in a meaningful manner. This has been shown to enhance a sense of agency and the processing of distress (e.g. Dilks, Tasker, & Wren, 2008; Lysaker, Wickett, Wilke & Lysaker, 2003). Along similar lines, all participants in this study have provided numerous examples in explaining how their approach towards the meaningfulness of their clients' experiences have assisted them in handling their distress while it also cultivated a climate of cooperation in the therapeutic relationship.

Participants' emphasis on how their clients' past and present lived experiences and relationships have influenced the development and maintenance of their distress and how this was related to the impoverishment of their significant relationships were also stressed. In line with these results, a number of research paradigms informed by diverse epistemological and ontological assumptions have unanimously presented evidence pointing towards the impoverishment of interpersonal relationships for people diagnosed with psychosis, while they have consistently ascribed a basic relational deficit and self-alienation as the sine qua non for this state (e.g. Fuchs, 2005; Parnas & Sass, 2001; Stanghellini, 2004). Participants understood their clients' psychotic experiences as meaningfully related to their life contexts and circumstances, as recognised in the phenomenological literature. For instance, Naudin et al. (1996) described a phenomenological investigation of auditory hallucinations and concluded

that these cannot be understood as disturbances in perception since the 'voices' the person hears are not isolated but rooted in a story from which they derive their meaning. Similarly, by suggesting that a person is always situated within a specific existential context, Parnas, Nordgaard and Varga (2010) in their phenomenological analysis of psychosis, concluded that it is impossible to provide a reliable, context-immune list of symptoms for psychosis as it cannot be understood outside and independently of the contextual psychological and existential circumstances of a person. Similar evidence comes also from cognitive models of psychosis – Birchwood, Fowler and Jackson (2000) developed a cognitive model of voice hearing, which asserts that the way a person evaluates voices will impact their emotional and behavioural responses to this experience. By employing a questionnaire methodology, the authors explored the experiences of voice hearers with a diagnosis of psychosis and found that people who experienced extreme powerlessness in their relationships with others were more likely to express analogous experiences through voice interactions. The researchers claimed that clients' interpersonal traumas can generate cognitive schemata, through which the perception of others as threatening emanates and therefore these affect their relationships and partly explain their tendency to isolate. It was suggested that these schemata not only affect the person's cognitive and affective states – and therefore their relationships with others – but also their relationships with voices. This is also in line with Chadwick's (2006) suggestion that clients' traumatic experiences assist the development of negative schematic experiences of self, which are personified through voice hearing. All of the above literature points towards the significance of lived experiences on the formation and understanding of psychotic phenomena and how these are meaningfully associated with the person's context. This is in line with participants' emphasis of their clients' past traumatic experiences in the process of making sense of their experiences. The association between traumatic experiences (not restricted to childhood) and the development of severe distress has a long history in psychological and psychotherapeutic research from both the qualitative and quantitative angles. For example, cross-sectional studies have provided consistent evidence that negative self-perceptions, severe anxiety, and depression in psychosis are highly related to traumatic experiences (Bebbington et al., 2004; Gracie et al., 2007). Additionally, childhood trauma such as physical, emotional and sexual abuse and neglect have been

consistently related to the shattering of the child's relational world (Stolorow, Atwood & Orange, 2002) and later developments of psychotic experiences (Morgan et al., 2007; Silverman, Reinherz & Giaconia, 1996; Teicher, Samson, Polcari & McGreenery, 2006; Varese et al., 2011).

With regard to how participants have understood and discussed their clients' self issues, two key difficulties in self-processes were identified: the impoverished sense of self and the undifferentiated self. These results point towards a phenomenologically informed cognitive apprehension of the construction of self in psychosis proposed by Trower and Chadwick (1995). The authors outlined two key forms of threat in the process of the construction of self, which are highly relevant to participants' accounts: the *insecure self* and the *alienated self*. The authors suggested that in the state of the *insecure self*, the person can construct self-presentations but others are usually perceived as neglectful or absent and consequently these self-representations are not adequately acknowledged, causing instability and impoverishment on the level of sense of self. Moreover, in the state of *alienated self* the person cannot differentiate herself from others because the other is experienced as overly present and intrusive and therefore the person struggles to differentiate her sense of self from the intrusive other. Participants' understanding of these self-issues has also been closely related to the manifestation of psychotic phenomena with the early and contemporary E-P literature having paid close attention to these (already discussed in the literature review). For instance, the notion of the *self* seems central in the conceptualisation of delusions and has been strongly connected to self-consciousness (e.g. Blankenburg, 1980; Naudin et al., 1996; Sass & Parnas, 2003; Sass & Pienkos, 2013). The forerunner of phenomenology, Franz Brentano, suggested that any reflection of the self must deal with the difficulties of consciousness first (Rancurello, 1968) even though in his later work he did challenge the primacy of self-consciousness (Gadamer, 2000). Phenomenologically conceived, the delusional state is characterised by an altered experience of the external world with preceding self-experience transformations (experience of one's own body, emotions and stream of consciousness). These suggested disturbances in self-awareness and self-experience are similar to the conception of depersonalisation (Parnas & Zahavi, 2002) in which the person's contents of consciousness are experienced as alien parts. Along similar

lines, Schneider (1959) described this state as an *ipseity* disturbance which manifests through several delusional forms such as thought insertion. Zahavi (2008) described *ipseity* or *mineness*, as the quality of 'being mine' of the experience on a pre-reflective self-consciousness level which reveals the self as a part of all our experiences. Sartre (1943/1956) has also suggested that self-consciousness at its most primitive state is about having a first-personal access to one's own consciousness and is characterised by an essential self-referentiality (ipseity). He noted, "Pre-reflective consciousness is self-consciousness. It is this same notion of self, which must be studied, for it defines the very being of consciousness" (Sartre, 1943/1956, p. 114). Heidegger (1926/2001) also appears relevant here as he also talked of *mineness* in the sense that the world that I experience is always mine and that nobody else experiences it the way that I do. In the case of psychosis, it has been hypothesised that this state of mineness becomes disturbed with the person struggling to disentangle his own intentions, cognitions and affects from those of others (e.g. Laing, 1965). This is closely related to participants' shared experiences and their understanding of their clients' difficulties to differentiate between themselves and others. Beth's assumption that her clients' diminished sense of self is related to the lack of having being sufficiently reflected by an other in the past, appears in line with psychoanalytic and E-P literature, which suggests that our sense of self and self-consciousness are closely related to the *look,* validation or invalidation of the other. Sartre (1943/1956) strongly supported this argument and asserted that people gain an ontological status and experience themselves as objects in the world only through the other: "…a man evaporates without an eye witness" (Sartre, 1945/1963, p.168). Additionally, Laing's (1965) concept of *ontological insecurity* appears pertinent here. He asserted that the person with psychosis experiences extreme existential anxiety that relates to the fear of the disintegration of self by others' intentions. The instability and uncertainty of our sense of self has been also extensively discussed in the psychoanalytic literature particularly by the self-psychology school of thought. For instance, Kohut (1972) in his conceptualisation of psychosis asserted that if a person has not been validated and acknowledged enough earlier on in life, she will later develop *narcissistic rage* and retreat to grandiose and paranoid states of mind.

Participants described how their attunement to their clients' paranoid states of mind has left them feeling deeply impacted on a cognitive, affective and embodied level. All participants implied that paying close attention to their own cognitive and affective changes during sessions assisted the sense-making of their clients' distress and therefore highlighted the relational emphasis in the process of constructing meaning. Along similar lines, Gelso and Hayes (2007) proposed that therapists' cognitive, affective and bodily states should be carefully considered throughout the course of therapy as they can considerably impact the therapeutic process and outcome. Moreover, Searles (1965) and Heimann (1950) have also strongly suggested that therapists pay close attention to their feelings when working with psychosis as these can possibly guide them towards a deeper understanding of the clients' processes. From a psychoanalytic perspective this points towards the concept of *countertransference.* Even though there are numerous psychoanalytic definitions of the concept that are not congruent with this project's epistemological grounds (as has already been discussed), for the purposes of this chapter it will be defined as the therapist's total response to the client. As I have already stressed, psychoanalytic explorations of therapists' experiences in working with psychosis are valuable considering the dearth of literature on the topic and psychoanalysis' emphasis on therapists' experiences compared to other approaches. In reviewing evidence from diverse approaches and discussing how clients' experiences impact therapists, Jennings (1987) argued that the experience of therapeutic work with psychosis from psychoanalytic, existential, person-centred and family psychotherapy perspectives has encouraged a more active use of the therapist's own feelings. But what might this 'active use' actually entail from an intersubjective perspective? In the discussion of the following theme this will become clearer by exploring participants' use of self and emotional transparency.

Despite participants' deep anxieties, fear and sense of helplessness, which appear in line with literature suggesting that the therapist's experience often comprises of narcissism, helplessness, avoidance and fear (e.g. Laufer, 2010), participants also expressed that their powerful emotional reactions towards their clients' experiences provided access to further connection and generated compassion. This is also in line with empirically oriented studies, which have explored

countertransferential feelings in therapists' work with psychosis and have suggested that positive and protective feelings such as sympathy and compassion were often expressed by therapists (Schwartz, Smith & Chopko, 2007). Moreover, Laufer's (2010) phenomenological exploration of psychoanalytic therapists' experiences revealed how therapeutic relationships provided the opportunity for therapists' transformational and learning experiences. Additionally, therapists have also expressed that therapeutic relationships taught them something essential about the human condition and reminded them of their human fragility. Similarly, this project's participants also addressed how clients have provided access to their own limitations and vulnerabilities, which is in line with earlier studies that pointed towards the discovery of the therapist's most deeply repressed feelings within her over the course of therapy (e.g. Benedetti, 1987). Despite the destabilisation that this might cause for the therapist, as results have revealed, it gradually allows a space for further bonding and can assist the development of a form of empathy towards the other which becomes less threatening and more accessible.

The consideration of both Rumke's (1941/1990) *praecox feeling* and Buber's *I-and-Thou* seem relevant here. I suggest that a conceptual blending of both contributions provide a dynamic alternative to the notion of countertransference from a phenomenological perspective. Their propositions assert that by closely examining one's responses towards the interlocutor, one can gain insight into their cognitive and affective states. Rumke's praecox feeling asserts that the therapist's emanating cognitive, affective and bodily reactions towards the client should be taken into consideration in 'diagnosing' psychosis. The totality of the therapist's response to the client, according to Rumke, reflects not merely the absence of direct contact but the client's state of alienation. It is suggested that the therapist's difficulties in connecting and engaging are related to self-relation changes as an outcome of being confronted with the client's otherness. The therapist's response can therefore inform the therapist about the client's state and the therapeutic dialogue can become the vehicle for exploring clients' being and how they relate to others. Additionally, Buber's dialogical analysis proposes a deeply felt communion between interlocutors experienced through intersubjective dialogue and points towards a state of shared cognition and affect. According to Buber, through dialogic connectedness both

interlocutors are immersed in one another without losing their sense of self and autonomy, however, attending to the shared state in-between them can assist their understanding of one another. In other words, Buber suggests that their inter-affective relatedness generates interpersonal understanding with their cognitive and affective states not completely hidden from one another. The conceptualisation of cognitions as not hermetically sealed within minds, and the assumption that the foundation of our understanding of another employs intersubjective perception and cognition is also stressed by theoretical considerations from the enactivist approach to cognition (e.g. Gallagher, 2001). The enactivist approach to social cognition suggests that social interaction can constitute social cognition. These approaches emphasise the embodied and embedded approaches to cognition and stress that our cognitions are constituted by the brain-body-world interaction. Gallagher (2001) for instance has proposed an enactivism informed interaction theory and suggested: "…in second-person interactions, the mind of the other is not entirely hidden or private, but is given and manifest in the other person's embodied comportment" (p. 203). This seems in line with participants' attention to the second personal interaction process, which suggests that interaction in itself constitutes their understanding of clients. As Fuchs and De Jaegher (2009) have proposed, sense-making is a relational and an affect-laden process. De Jaegher and Di Paolo (2007) defined this participatory sense-making as "…the coordination of intentional activity in interaction, whereby individual sense-making processes are affected and new domains of social sense-making can be generated that were not available to each individual on her own" (p. 13).

6.2.2 A relational approach to therapy

Participants portrayed a relational approach to their practice and their intersubjective work with psychosis, as exemplified through descriptions of their therapeutic approach which emphasised the emergent here-and-now relational 'microcosm' between themselves and clients. They all indicated the importance of developing and exploring the therapeutic relationship in their work and overall the experience of a good therapeutic relationship stretched beyond a satisfying therapeutic alliance and was described as situated on a platform of dynamic

interpersonal exchanges. Even though the role of therapeutic rapport in the psychotherapy for psychosis has been significantly undervalued in the literature, existing evidence points not only towards the possibility of robust therapeutic alliances but also towards how these are related to positive outcomes and recovery (e.g., Evans-Jones, Peters, & Barker, 2009; Sachse & Elliott, 2001). As Stanghellini and Lysaker (2007) have demonstrated, intersubjectively informed psychotherapy is a process that takes place not internally but externally in the space in-between therapist and client, and therefore that space should be given particular emphasis especially in the case of psychosis, where relational difficulties are considered as its sine qua non characteristic. Evidence that the therapeutic relationship consists of an important area for exploration in therapeutic work with psychosis comes from several approaches, including the psychoanalytic (e.g. Fromm-Reichmann, 1950; Searles, 1965; Sullivan, 1962; Harder & Folke, 2012), person-centred (e.g. Rogers et al., 1967), integrative (Lysaker, Lysaker & Lysaker, 2001), E-P (e.g. Binswanger, 1963/1993; Pienkos & Sass, 2012; Minkowski, 1933/1970) and even the cognitive approaches that traditionally have not been considered sensitive enough to the processes of the therapeutic relationship. For instance, Hasson-Ohayon (2012) suggested that traditional CBT approaches to psychosis do not sufficiently address the person's metacognitive and relational difficulties and therefore recommended an integration of intersubjective approaches to existing CBT models in order to integrate intersubjective processes into CBT interventions. She particularly recommended the importance of focusing on explorations of the here-and-now and the therapeutic relationship which suggests the benefits of the therapist's self-disclosure. A recent and exciting evolution is observed in cognitive therapy for distressing psychosis (Chadwick, 2006), where among other advances, it honours the exploration and validation of the therapeutic relationship and highlights the significance of client-therapist collaboration. Also, a 'Metacognitive Narrative Psychotherapy' approach that is informed by both metacognitive models and dialogical narrative understandings of self and psychosis has been developed by Lysaker, Lysaker, and Lysaker (2001), which particularly addresses the in-session explorations of the therapeutic relationship. Additionally, mentalization-based approaches to psychotherapy for psychosis that are in line with phenomenological approaches and also consider *ipseity* disturbances in psychosis (the difficulties of a person in having a

sense of being the subject of one's experience), provide evidence that impaired mentalization (the capacity to think about mental states in the self and others) is increasingly considered as a vital area for exploration in psychosis (e.g. Brent, et al., 2014). Brent et al. (2014) suggested that mentalization-based psychotherapies could facilitate recovery and assist the person in developing her social understanding by inviting her to the evaluation of how her states of mind are related to specific interpersonal circumstances including the therapeutic relationship.

In a recent mixed methods study, Green at al. (2008) have explored how people with severe distress evaluated their long-term relationships with therapists who provided recovery-oriented approaches and concluded that in the cases where the therapeutic relationship was addressed and collaboration between therapist and client was considered fundamental, a significant decrease in psychiatric symptoms and an enhanced quality of life was mentioned. Additionally, in their grounded theory analysis of therapy and recovery processes in psychosis, Dilks, Tasker and Wren (2012) analysed nineteen taped transcripts from therapy sessions taken out of twenty-six interviews with psychoanalytically oriented psychologists and found that the therapist's main role was understood as a dialogical process constantly negotiated between therapist and client. The researchers concluded that these dialogical processes are fundamental for the psychotherapy of psychosis by supporting therapists' efforts to preserve an observational standpoint on their own processes and allowing them to provide new viewpoints on distressing experiences to the client. From an intersubjective perspective, exploring and building the therapeutic relationship is therefore perceived as a pivotal aspect of therapy (e.g. Gabbard, 1994) and good levels of therapeutic alliance have demonstrated greater acceptance of therapy, less usage of medication and better long-term outcomes (Novalis, Rojcewicz & Peele, 1993).

The Participants' tendency to prioritise and explore relational processes within their therapeutic relationships during sessions was also demonstrated through their descriptions of employing the first and second person perspectives. More specifically, the use of first person perspective employed the participants' use of self, emotional transparency, and careful self-disclosures while the second person perspective

employed mirroring, and the acknowledgment and validation of clients' experiences by providing the perspective of another 'you'. Participants' introduction of the first person perspective in their dialogues with clients has also been accounted in the literature from diverse theoretical approaches. For instance, McWilliams' (1994) psychoanalytic approach, suggests that especially in the case of psychosis, the therapist's demonstration of trustworthiness must pertain to a more active effort in expressing her acceptance of the client and being more emotionally honest compared to the work with other client groups. She suggests that the therapist working with psychosis should offer a more transparent acceptance and validation of clients' way of being and that therapy requires more emotional disclosures compared to other client groups because as she explains people with psychosis could easily feel 'betrayed' if their therapist consistently conceals her emotional state from them. Moreover, in a recent paper published in *The Psychologist*, Ruddle and Dilks (2015) have commented that their discussions with colleagues who work with psychosis revealed numerous and strategic use of self-disclosures in their therapeutic work with psychosis. They also added that in their personal work have also noticed the particular value of self-disclosures due to the specific challenges in engaging people who are distrustful or socially isolated. They explained that because of the stigma and social exclusion resultant from a diagnosis of psychosis, the development and maintenance of relationships are challenging tasks and therefore the therapeutic relationship provides the client with an extremely valuable opportunity to experience a trusting relationship, with therapist's self-disclosures, therefore, assisting this process. This is in line with participants' understanding of the role of self-disclosures particularly in the cases where clients' intense paranoia was associated with frequent uses of self, as in the cases of Beth and Carla. Similarly with results from previous studies (e.g. Ruddle & Dilks, 2015; Traynor, Elliott & Cooper, 2011), Beth and Carla asserted that the explanation of their thinking, feeling and motives behind interventions was more often employed in their work with intensely paranoid clients who tended to misapprehend their comments. Offering them transparency about their motives and actions decreased their suspicion and assisted the development of trust and alliance. Even though the issue of trust was understood as essential to the development of therapeutic relationships, it is important to note that, as noted by Brown et al. (2009),

there is a scarcity of research exploring trust within mental health settings and it, therefore, merits further research.

The development of trust and maintenance of empathic attunement was also associated with participants' employment of the second person perspective in sessions. Moreover, the majority of participants' tendency to address clients in the second person was understood as part of the process of assisting them in developing a more robust sense of self and a capacity for self-empathy. Participants' understanding of clients' difficulties in differentiating from others seems to reflect the use of the second-person perspective, which according to their accounts assisted the process of cultivating the sense that others are distinctive from oneself. Likewise, Lysaker and Lysaker (2006) suggested that therapists could reflect the influence of clients' experiences on their social relationships and emphasise mirroring from the second person perspective of whatever the client is revealing from moment to moment. The authors suggested that by paying attention to the process of being perceived and experienced, and by assisting the client in developing an awareness that others are aware of them, this can help the client to develop a less threatening apprehension of others and a more stable sense of self. In phenomenological terms, the client is able to accept the therapist's reflection of her in the second person and therefore an affirmation of the client's self-consciousness is highlighted. From a Merleau-Pontian point of view (1945/1962) (see the consideration of Merleau-Ponty in the literature review) we might suggest that since perceptions and emotions are not exclusively located inside the person but are opening her into the world and connecting her to the world and others, through the second person perspective the therapist and client can generate an intersubjective understanding within the context of the therapeutic relationship, which can help the client to construct a coherent narrative about their self and therefore build a more stable sense of self. Stanghellini and Lysaker (2007) have analysed vignettes from several sessions of psychotherapy for psychosis and showed that this approach has assisted clients to develop a first and second person perspective, which were both related to their recovery. This has also been supported by other research, in which clients revealed that the process of recovery from psychosis involved a strengthening of their sense of self (e.g. Davidson, 2003). From a Buberian vantage point, the therapist is, therefore, *confirming* and accepting the

client by making her present, which he considered as the only route to becoming a distinctive person (Buber, 1921/1996).

From a Buberian perspective, an intersubjective approach to therapeutic work necessitates that the therapist relates to the client as a whole, which means bringing one's totality into the relationship and being able to carefully draw on all facets of oneself. Participants' use of self and emotional transparency with clients in these terms was understood as a hallmark in their approach to clients and was found in the flexibility of therapeutic boundaries. Additionally, participants' articulated tendency in adjusting the therapeutic boundaries – found extended beyond the space of actual therapy – was also related to the process of confirming clients and accepting their circumstances and experiences. This proved to be an extension of their relational approach to therapy but additionally it has proven to be affected by the context within which participants found themselves working. Their articulations of boundary crossings comprised of issues to do with self-disclosures, length and places of sessions, physical touch, activities outside of the therapy room, incidental encounters and some forms of dual relationships. All participants understood boundary crossings as helpful in their clinical work and their meaning was found situated within the context in which therapy took place such us the nature of clinical settings, consideration of particular client issues and the therapist's own processes in response to clients difficulties. For instance, participants who were involved in community work as part of their professional responsibilities expressed more intense interactions and more boundary crossings. These results support similar findings elsewhere. Priebe and McCabe (2006) suggested that there are crucial differences between services delivered in the community for people with severe distress compared to those provided within pure psychotherapy contexts. Their research's results proposed that interventions in the community comprised of more intense interactions in both quality and quantity and therefore professional/personal boundaries became intensely permeable, something the authors suggested has not been satisfactorily addressed in the literature. The flexibility of boundaries has also been addressed by other studies that have explored therapeutic relationships in work with psychosis, and suggested that the flexibility of boundaries was generated by contextual factors and was understood as an integral and beneficial part of a responsible practice and involved

sensitive and suitable adjustment of therapeutic parameters (Mearns, 2003; Traynor, Elliott & Cooper, 2011; Warner, 2001).

6.2.3 Ruptures in relatedness and the lived experience of being-with

Participants appeared to understand the therapeutic alliance as part of a continuous process of intersubjective negotiation and suggested through particular examples that the emergence of inescapable ruptures in relatedness signified opportunities for the transformation of therapeutic relationships despite the experience of intense reflective disruptions. As Buber (1947/2006) has argued, in any authentic dialogue we tend to oscillate between closeness and distance, acceptance and disagreement. The implications of Buber's viewpoints on dialogue to the psychotherapy of psychosis as Buck, Buck, Hamm and Lysaker (2015) have suggested are tremendous, and advocate that the therapeutic encounter can encourage reflection if the therapist provides clients the opportunity to move back and forth from I–Thou to I–It modes of relating. Buber suggested that an oscillation between the two should be expected and acknowledged. The current analysis revealed that these oscillations were also significant for participants' capacities for reflection. The majority of participants elucidated the importance of moving in and out of the edges of the therapeutic alliance in an effort to make sense of what lay in the space in-between. This demonstrated that their immersion in their clients' experiences implied subsequent detaching in order for meaning to be generated and also in being able to evaluate how these have personally impacted them. In other words, a Buberian approach to intersubjectivity advocates that both dialogue (I-Thou) and monologue (I-It) are essential in the therapeutic setting. Even though Buber (1921/1996) suggested that I–Thou interactions occur through authentic dialogues, he also proposed that when an I–Thou encounter has been experienced, it cannot be sustained for extended periods of time since its intensity requires that it must alter to an I–It encounter in which the other becomes analysable and classifiable (e.g. Carla: "(…) *really, I couldn't bear the fact that we came closer).* This resonates with the participants' tendency to employ psychiatric classifications in order to describe their clients'

difficulties when unfolding moments of therapeutic ruptures (elsewhere absent from their interviews) and therefore possibly assigning an illusion of objectivity in their difficulties in sitting with the unknown. Existentially approached, principles cannot substitute our experience (e.g. Deurzen-Smith, 1990) and the space in-between requires that we continually attend to our experience and the unknown that is embodied in the other and the space in-between. Kierkegaard's understanding of dreading the unknown appears pertinent here. He asserted that our fear of the unknown as infinite brings awareness to our own finiteness and therefore generates dread (Kierkegaard, 1844/1973). The therapist is therefore invited to acknowledge and tolerate the dread evoked by the in-between uncertainties, an extremely demanding task especially in the case of psychosis, which resonates with participants' experience of relational ruptures.

Delving deeper into participants' experiences of relational ruptures and parallel with results from previous studies (e.g. Wilson & Lindy, 1994), the analysis revealed that participants' empathic attunement to clients was understood and described as demarcated when faced with clients' experiences that provoked strong emotions in them. Participants' sense of self, cognitive and affective states during critical disengagement moments were described as going through several transformations (e.g. John: "*the distortions will appear and manifest themselves in the intersubjective relationship with the therapist*", Carla: "*I feel attacked symbolically, my thoughts, and it is very strong*", *"You know, I felt that I suddenly became something I wasn't aware of before)*. This kind of rapid cognitive and affective changes points towards participants' intense involvement with clients, with whom they are deeply engaged in a reciprocal dialogue in which no one is left untouched. Atwood (2012b, p.22) who has worked extensively with psychosis from a phenomenological/psychoanalytic perspective illustrated similar remarks: "(…) there is no such thing as detached observation. It means that the transformations that occur, if any do, include both participants. (…). A psychotherapeutic dialogue, if it is in any measure successful, always illuminates and transforms the worlds of both of the people involved, and as far as I am concerned, this is actually self-evident." Along similar lines, Rumke (1941/1990, p. 336) suggested, "As interpersonal relations are not one-sided, the investigator examining a sufferer from schizophrenia notices

something out of the order within himself" (p.336). Rumke implied that the therapist's self-relation changes and the resultant fear and transformations of cognitive and affective states are understood to be related to the experience of her disconnectedness from the client. Moreover, Fromm-Reichmann (1952) understood the therapist's fear as a common emotional response related to the sense of threat emanating from the content of a client's anxiety that makes her work particularly demanding whilst distracting her from the client. The therapist according to Fromm-Reichmann "…may become too preoccupied with his own need for safety, security and prestige, hence too defensive and argumentative, to relate himself successfully to schizophrenic patients" (p. 92). Additionally, both Karon (1992) and Searles (1965), who have worked extensively with psychosis, have all argued that therapeutic work with psychosis can generate terror in the therapist as her connectedness to the client and the apprehension of her psychotic state brings to the fore painful truths about human existence that the therapist might have blocked from awareness. Similarly, participants in this study discussed how the revelation of personal agonising limitations in their work caused several destabilisations and communicated that the associated fear had a remarkable effect on their therapeutic stance, while it was related to the experience of relational ruptures. Carla's reflections on her experience of a strong therapeutic rupture portray this poignantly: "*This patient's unstable sense of self threatened me but not only, I mean (p), it also enlightened something, to a certain extent, very existential about my sense of self in many ways".* As Atwood (2012b, p.53) commented: "When we listen to the human stories told by our most disturbed patients, we also rediscover aspects of ourselves. It has been a central aim of my lifework to erase the sharp boundary that has been drawn to separate madness from sanity, returning the phenomena of severe psychological disorders to the circle of the humanly intelligible".

Participants also demonstrated that in the cases in which clients evoked severe anxiety and feelings of confusion in them, in order to 'protect' themselves they tended to erect barriers between their own reality and that of the client's. Along these lines, Campling (2015) suggested that as defensive walls are erected, feelings of vulnerability become more profoundly suppressed, with the capability for empathy declining. The author has stressed that our contact with emotional distress can be

equally disturbing with that of the person experiencing it, and therefore defensive styles of coping are regularly generated in the professional in an effort to protect herself from experiencing resultant feelings of confusion and emotional pain. The experience of becoming overly attached to clients and the participants' sense that clients became overly attached to them appeared to have generated a subjective sense of autonomy violation with resultant experiences of rupture. I suggest that these can be understood as the expression of agency at the expense of relatedness. Similar to accounts from other authors (e.g. Searles, 1965) it could be also proposed that participants' anxiety in sharing a subjective symbiotic oneness with clients made them feel incapable of experiencing themselves as differentiated and hence the subjective autonomy of their sense of self was experienced as under threat. Consequently, these ruptures can be understood as resulting from the dialectical tension between the need for autonomy as against the need for relatedness. Participants' experiences of ruptures in relatedness were also linked to disruptions in their autonomous reflective capacities. I propose that their experiences of strong emotional intimacy with clients – at times described as a source of threat – can shed light on the experiences of difficulties in reflective action. Despite the emphasis on the meaningfulness and comprehensibility of their clients' experiences and worldviews and whereas the literature consistently refers to clients' lack of capacity for self-reflection (e.g. Brent et al., 2014; Parnas & Sass, 2001), what became evident through all participants' accounts was their own disruptions of reflective capacities that appeared as an inescapable phenomenon in their work. Therefore, there seems to be a parallel process in place between participants and their clients with regards to reflective difficulties. Even though the literature keeps pointing out that people with psychosis struggle with self-reflection, it is interesting to observe that participants have also at times struggled with their own reflective capacity. Considering the complex processes of reflection in the space in-between client and therapist as results have revealed but as is also evident in the literature (e.g. Brent, 2014), and the experience of intimacy in the therapeutic relationships experienced as overwhelming for both clients and therapists (e.g. Searles, 1965), I particularly emphasise the vital nature of reflectivity in the space in-between given that it is particularly crucial to being able to understand clients' experiences. As Buck et al. (2015, p. 157) have suggested, the literature lacks a systematic consideration "…on the kinds of processes that occur between clinician

and patient that promote the kinds of reflection which are at the core of recovery". As already mentioned, a significant implication that emerges from applying Buber's (1921/1996) approach to dialogue is that for a therapeutic relationship to promote a genuine and transformative reflection both interlocutors in the dyad must be able to move back and forth between I-Thou and I-It modes of relating.

Another common characteristic among participants was their expressed self-awareness related to self-doubt and a sense of incompetence during their descriptions of relational ruptures in sessions with clients. While in the field of psychotherapy in general the therapist' self-awareness is considered as valuable for the therapeutic process (e.g. Norcross, 2000), all participants have at times described distracting feelings of incompetence that were understood as an inescapable part of their work with psychosis (e.g. Paula: "*I'll be struggling with my confidence regarding the interventions",* Barbara*: "it doesn't give her anything, it has nothing to offer").* Although feelings of uncertainty about one's effectiveness are the most commonly reported ones in the profession of psychotherapy irrespective of years of experience and expertise (Mahoney, 1997) and it is not unusual for even experienced therapists to feel suddenly incompetent and hopeless in the face of extremely anxious and/or traumatised clients (e.g. Herman, 1992), it is important to contextualise these in the case of working intersubjectively with psychosis in order to shed light on the underlying dynamics and how these are related to participants' ways of being-with clients. As I have already highlighted in the results' section, it may be that participants' sense of excessive responsibility and powerlessness in the cases of relational ruptures might be mirroring clients' state of helplessness. This exacerbates participants' difficulties in finding active means to encourage clients towards dialogue. Even though all participants stressed the experience and importance of collaborative work, this did not negate the emergence of incongruity and uncertainty in their therapeutic relationships, which in turn generated anxiety and destabilisation. Similarly, Dilks, Tasker and Wren (2012) suggested that even though therapists have understood the process of therapy as a collaborative one, their results revealed that it was the therapist who assumed responsibility for sustaining the core processes in therapy. The researchers identified an assumption of responsibility as a consequence of therapists' efforts to maintain dialogues in the space in-between. Likewise,

considering participants' therapeutic emphasis on dialogical and relational processes, it is not surprising that in those cases of relational ruptures and difficulty in sustaining the dialogue, feelings of uncertainty and powerlessness were generated in participants with a tendency to assume further responsibility and in the face of therapeutic ruptures they felt lost and incompetent. Similar feelings of confusion and incompetence were revealed by Gendlin (1967, p.372) who described the experience of working with psychosis in the following way: "We wonder what to do with all this richness of events which occurs in our own moment-to-moment experience (…). We are in conflict, not knowing whether to push harder or to attempt being even safer. We blame ourselves for too much helpless waiting, then minutes later, for too much interruption, pressure, and demand". Participants have also demonstrated that in the state of therapeutic impasses and related difficulties in sustaining the dialogue, participants' reflective capacities were experienced as minimised. The relationship between the sustenance of dialogue and intact reflective capacities was also explored in Allen, Burbach and Reibstein's (2012) IPA study. The researchers interviewed seven clients who had attended a family intervention service for psychosis and their results revealed that sustaining the dialogue within sessions enabled both therapists and clients to hold a reflective stance regarding clients' distressing experiences. Similar to this study's results, what seems to have assisted the maintenance of reflectivity was the creation of meaning inherent in a dialogue that assisted the validation of multiple perspectives.

As the analysis of findings has revealed, participants' difficulties with reflection, which were closely linked to relational ruptures, were also related to experiences of sense-of-self-transformations. Incidents of extreme cognitive, affective and sense-of-self disruptions in the case of relational ruptures were exemplified by Paula's and Carla's descriptions of dissociative and depersonalisation experiences. Even though all participants portrayed cognitive and affective disruptions, the cases of Paula and Carla are both worth taking into further consideration as they shed light on critical intersubjective processes in the ruptures of relatedness. Both participants expressed that in these cases, 'contents' of their consciousness were experienced as alien parts, which in a way seem to parallel clients' experiences (delusions and hallucinations). In the cases in which Paula and Carla experienced thoughts and

emotions that seemed incongruent with their pre-established sense of self, they felt alienated in the space in-between and also estranged from their own sense of self. In the state of this intersubjective destabilisation their first person perspective and self-experience were experienced as suddenly shaken. Not able to find an alternate self-position in order to survive this decenteredness and while struggling to maintain some aspect of self-consistency, the first option available seemed to be attuning to their clients' affective states. This demonstrates Bernstein's (2002) argument – commenting on Levinas' assertion that to overcome alienation the person should orient herself towards the other and not through a flight into the self – who suggested that the alternative perspective of the other allows us to 'escape' from our self and transcends it. However, if we assume that a similar kind of 'escape' took place in participants' cases, this seems to have generated a sense of intense fear and at times was experienced as an intrusion to their autonomy (e.g. Paula: "I felt something was thrown at me"). Phenomenologically conceived, these transformations are considered to take place on a pre-reflective self-consciousness level (Zahavi, 2008). Merleau-Ponty (1968) seems relevant here when he claimed that our immediate or pre-reflective embodied self-awareness is intersubjective in nature. In these terms, participants' lived personal experience can be considered fundamentally and inextricably immersed in the space in-between, an immersion that may be associated with perceptual and affective processes that transforms their ontological framework of self-experience and disconnects them from meaningfully bonding with clients. While this is not the participants' total experience, it is worth discussing because it portrays how powerfully affecting intersubjective work with psychosis is for therapists. The analysis suggested that participants' disruptions of their fluidity of affective experiences affected their directedness towards the moment of the therapeutic encounters and contributed towards the disruption of relatedness. Taking a Binswangerian and Buberian intersubjective approach, I suggest that these forms of disruptions are given birth at the interface between self and other and are related to how participants processed their clients' otherness. Merleau-Ponty (1945/1962) emphasised that through our lived experiences with the other, a revelation of their aspects of self that we were previously unaware of can shed light on aspects of our own self-alterity (already discussed in p.48). Considering a Merleau-Pontian intersubjective approach that apprehends self-alterity as an extension of the other's

otherness, it can be tentatively suggested that participants' lived experience of being confronted with their clients' otherness and resultant experiences of depersonalisation and dissociation might indicate their own structures of self-alterity. In Merleau-Pontian terms (1945/1962) the therapist's self-awareness consists of an awareness of the client – and therefore their psychotic processes – and her openness to the client is therefore predicated on the assumption that she is to a certain extent a stranger to her own self. I suggest that this has implications for an intersubjective approach to the psychotherapy of psychosis. The phenomenological thoughtfulness on the otherness of psychotic experiences and the responsive manifestations of self-alterity in the therapist (depersonalisation and dissociation) seem therefore not only strongly interrelated but can also enlighten the psychotherapy of psychosis in a manner which could tackle the particular needs and vulnerabilities that are unique to therapists involved in this kind of work.

Merleau-Ponty asserted the possibility for an ontological unity between persons by encountering the other's alterity (Ware, 2006). This also relates to Vygotsky's (1962) contention that a person's intrapersonal world consists of an internalisation of interpersonal existence. It can be therefore inferred that participants' experiences not only challenge the Jasperian (Jaspers, 1963) conception of psychosis's incomprehensible otherness but also accentuate its penetrative authority. By being penetrated by clients' otherness, participants' self-relational stance went through several alterations, which point towards the assertion that a person's self-experience is established and inhabited by the other who pervades through and disrupts the experience of autonomy in relatedness. From an I-Thou Buberian point of view, we can suggest that through their genuine dialogues with clients, participants became part of the client's otherness, and the resultant terror and accompanied felt sense of autonomy violation have generated the need for disentanglement with relevant disembodiment, depersonalization, and dissociation experiences. This very intense experience of participants' self-decenterness in the state of being penetrated by clients' otherness, challenges the notion of autonomy from an intersubjective perspective while it also demonstrates our enmeshment with the world and others (Heidegger, 1926/2001). Heidegger's conception of *Dasein* as *Mitsein* (being-in-the-world-with-other-people) suggested that one is enmeshed in the world with Others

and one cannot extricate oneself from this world: "The world of Dasein is a with-world (Mitwelt). Being-in is Being-with-Others" (Heidegger, 1926/2001, p.155). A manifestation of this, which also points towards the intersubjective constitution of common cognitive and affective experiences is illustrated in the clinical literature in cases of a shared psychosis, such as in *folie a deux* (e.g. Wehmeier, Barth & Remschmidtet, 2003) where two or more people are experiencing the same psychotic experiences. Even though this phenomenon remains largely unexplored, the limited literature seems to suggest that the clients' psychotic experiences can become 'transmittable' to the therapist in occasions of therapeutic interchanges over a prolonged period of an intimate therapeutic relationship (e.g. Maroda, 2004). Similarly, in his passionate account of a case study with a client experiencing intense hallucinations and delusions, Atwood (2012b, p. 51) commented: "(…) I began to feel a trembling and a stirring in my lower abdomen, as if the energies had somehow entered into my body as well. This effect, rather disturbing in the moment of its occurrence, arose because of the deep identification with the concretizations of her experience I had been attempting to cultivate". This is similar to participants' experiences which left them feeling deeply affected with their sense of self experienced as unstable and destabilised and seem to parallel their understandings of clients' sense of self difficulties and point towards the angst associated with the tension of being a self (Kierkegaard, 1844; Heidegger, 1926/2001; Sartre, 1943). Ricoeur (1965/1970) also appears relevant here with his suggestion that the method in which we sense our selfhood is primarily disturbed because our experience of ourselves is emotionally fragile and human thinking is always "wounded thinking" (cogito blessé). Therefore, from a Merleau-Pontian perspective, the delicate integrity and imperfect structure of the project of developing as an embodied self applies to every embodied subject, whether with or without psychotic difficulties, which resonates with participants' experiences. The realisation of this limitation seems highly relevant to therapeutic work with psychosis. It seems to generate an intense vulnerability in therapists, which should be anticipated and thoroughly acknowledged and reflected.

Despite the multi-layered challenges already discussed, all participants portrayed a strong confidence regarding the benefits of the psychotherapy for

psychosis for both their clients and themselves. Highlighted in their accounts, the at times mistrustful attitude towards their contributions for the generation of therapeutic change in consideration of their clients' recovery was understood as an inextricable part of the therapeutic journey. Their confidence in the benefits of therapeutic work that outweighed their mistrust seems to have assisted the development of strong alliances and the encouragement of engagement. These results are in line with a study by Evans-Jones et al. (2009), which highlighted the prominence of therapists' confidence and experience in establishing therapeutic relationships within the context of CBT for psychosis. Moreover, supporting evidence presented from earlier (e.g. Binswanger, 1963/1993; Fromm-Reichmann, 1954; Laing, 1965; Sullivan, 1962) and later studies (e.g. Lysaker et al., 2013; Atwood, 2012a), are in line with participants' descriptions that revealed experiences of genuine partnerships in the process of exploring the meaning of their clients' experiences and the underlying dynamics of the therapeutic relationship. Their experiences of connectedness and mutuality were demonstrated by illuminating how connectivity and reciprocity assisted the development of a safe and dynamic space that generated meaningfulness. Similarly to Atwood's (2012b) accounts, the personal significance of connectedness for participants was illuminated through an emphasis on the opportunities provided to rest their anxieties on their clients' experiences and worldviews. By coming genuinely close to their clients and through their emotional openness and immediacy, participants appeared to realise experientially how crucial it is to use the relationship, while their emphasis on the priority of the therapeutic relationship as the generator of change and meaningfulness is in line with consistent and substantial amounts of research advocating that the therapeutic relationship has a superior effect on outcomes than the particulars of any theoretically-driven intervention (e.g. Wampold & Imel, 2015).

6.3 IMPLICATIONS FOR COUNSELLING PSYCHOLOGY

6.3.1 Implications for practice

The phenomenological understanding of psychosis explored in the literature review, which consisted of a blending of earlier and more recent theoretical and clinical phenomenological contributions, was implicitly but significantly reflected in all participants' lived experiences and points towards a new life for the psychotherapy of psychosis in the light of phenomenology as has also been pointed out in recent literature (e.g. Perez-Alvares et al., 2008). This was partly expected considering CoP's emphasis on the phenomenological (e.g. Lane & Corrie, 2006). Even though the majority of participants did not theoretically identify with the E-P paradigm, the detailed exploration of their lived experiences has pointed towards sensitive intersubjective issues endorsed in the principles of phenomenologically informed psychotherapies for psychosis - such as clients' intersubjective breakdowns and issues with self, the emphasis on the endorsement of a second person perspective and therapist's self-disclosures, matters around the co-creation of meaning and an emphasis towards the exploration of the here-and-now processes of the therapeutic relationship. Taking into consideration participants' relational emphasis that strongly resonates with CoP's practice, several subjective implications can be noted. As du Plock (2006) has suggested, CoP has traditionally considered the therapeutic relationship as the strongest therapeutic medium.

Contrary to the view of the therapeutic relationship as irrelevant to the provision of psychological interventions for the case of psychosis (Coleman & Jenkins, 1998), the results of this project point in the opposite direction. Participants' emphasis on the value of the therapeutic relationship and their indications of the significance of employing a relational approach to the psychotherapy of psychosis not only resonate with recent phenomenological research (e.g. Stanghellini & Lysaker, 2007) but also with current – though limited – qualitative research conducted specifically on CoPt's work with psychosis (Larsson, 2010; Larsson, Brooks, & Loewenthal, 2012). They suggested that irrespective of participants' theoretical orientations, the common focus was oriented towards the therapeutic relationship,

which also resonates with NICE (2014) recommendations. Even though NICE considers empathic relationships as an inextricable part of recovery-focused approaches to psychosis, it is very discouraging that these recommendations remain loosely presented since they are not highlighted in the psychological therapies options. Also, it is clearly recommended that counselling and supportive psychotherapy should not be routinely offered to people with psychosis, especially in inpatient settings. However, some of the experiences presented in the present research, such as Carla's intersubjective work offered on an acute psychiatric ward for the last twenty-two years, strongly suggest that intersubjective psychotherapy can be helpful for people with distressing psychosis.

Considering the upward trend in qualitative research that strongly recommends relational approaches for psychosis, these kinds of contradictions need to be constructively challenged while clinical guidelines should be reviewed in light of these qualitative research results. As Tan, Stokes and Shaw (2009) have recommended, even though qualitative research is progressively being used by NICE's clinical guideline developers there is certainly room for further recognition, evaluation, and amalgamation of qualitative evidence in clinical guidelines. Additionally, in a broader sense the *common factors model* in psychotherapy seems pertinent here. Meta-analyses have provided strong and extensive evidence that support the common factors theory in the field of psychotherapy and suggest that it is not the type of therapy that is important, but the common factors such as therapeutic alliance, empathy, cultural adaptation, and therapeutic process (Wampold, 2015). The common factors model of therapeutic change and the evidence that the relationship is critical to any kind of psychotherapy above and beyond the model employed (Wampold & Imel, 2015) suggests that this extensive evidence needs to be critically addressed in clinical guidelines. Both CoP and phenomenologically informed psychotherapies, which prioritise the therapeutic relationship and process, need therefore to systematically address these issues on a political and strategic plan level. Moreover, considering the growing number of CoPts employed in the NHS and their significant contributions to clients who are given a psychiatric diagnosis (Cooper, 2009), CoP through its professional bodies must therefore systematically and methodically map the existing policies, their clinical guidelines and the obstructions

in the policy processes regarding the implementation of therapeutic approaches to psychosis and identify influential policy stakeholders in order to inform future policy development and implementation. Despite the political, social and economic challenges that come along with this recommendation, I strongly consider that it is ethical response not only for our professional identities which comprise the qualities of a deeply caring profession but similarly for our clients' complex needs and difficulties.

Additionally, even though the results suggest that CoPts are tremendously well placed to provide therapeutic support to persons with psychotic difficulties, it seems clear that further encouragement is required to bring more CoPts into this field. Hence, it is suggested that there is a pivotal necessity for the profession of CoP to be represented in diverse professional areas, particularly in those where the medical model of distress predominates, in order to safeguard the commitment of our work towards our clients' wellbeing.

The consistent employment of diagnostic labels and the medicalisation of distress is based on the assumption that the so-called 'mental illness' is located within the person and her brain while her disturbed experiences are generally defined as phenomena that are separated from the life context in which they are expressed (Irarrazaval & Sharim, 2014). This project's intersubjective focus which is clearly linked to the recovery movement asserts instead that any form of experience always includes the person's relations and interactions with others and strongly recommends a more comprehensive perspective of psychotic experiences as these can be understood within the contexts of a person's life. Similarly, results have also shown that participants' destabilising experiences were strongly interconnected with the context of therapy and working settings but mostly to the deeply affecting therapeutic bonds developed with clients. More specifically, results revealed that intersubjective work with psychosis consisted of an intense process of altering moments between distance/separation and relatedness/confrontation for both clients and therapists. It is therefore suggested that this dynamic form of oscillation in the space in-between should be given particular emphasis considering that these can generate rapid affective and cognitive changes and reflective breakdowns, with accompanying

transformations of the therapist's sense of self. Participants have suggested that the oscillations between emotional distancing and relatedness have been significant in the maintenance of their reflective capacities and therefore this is something practitioners should take into consideration when working interrelationally with psychosis. Moreover, results clearly suggest that the prevailing psychological interventions for psychosis should consider the intersubjective and dialogical processes that can facilitate the appropriate reflection and acknowledge the forms of relatedness implied by the intersubjective approaches of prominent thinkers such as Buber and Merleau-Ponty. Despite participants' successful efforts to deeply and relationally engage and connect with clients, results point also towards a careful consideration of the resultant reciprocal connectedness and how this can affect the overall therapeutic relationship and outcome. Strong therapeutic bonds in the psychotherapy for psychosis can be deeply affecting for both client and therapist and this should be anticipated.

Participants have clearly demonstrated how their attachments to clients generated a sense of subjective threat and destabilised their sense of self to the extent of experiencing moments of disembodiment and disruptions in the fluidity of their affective experiences. This points towards the intersubjective and fluctuating nature of our sense of self, and the E-P approach can significantly contribute towards this essential insight – especially in therapeutic work with psychosis, where issues relating to the sense of self for both clients and therapists prevail. Existentially perceived, the inherent difficulties in self-awareness remain an essential difficulty in all varieties of human existence, whether in the presence or absence of psychosis and this should be acknowledged. Along these lines, results have suggested the employment of 'self-as-a-process' or 'self-as-transformation'. I take the ancient Delphic apothegm 'Know Thyself' as an invitation to turn towards this process rather than turning towards the self as a fixed structure. The medusa gaze of the essentialist position objectifies the self by conceptualising it as a substantial and solid structure. It is a gaze turning 'someone' into 'something' inflexible, stone-like, and permanent, therefore negating our temporal nature and refusing to embrace the elusiveness of selfhood. The existential outlook takes a Heraclitean spin instead: everything flows and nothing stands still (Kirk, 1954). I therefore suggest that the existential approach, which assumes that the self cannot be taken for granted as it is constantly in a state of

transformation (e.g. Kierkegaard, 1844/1973; Heidegger, 1926/2001), must be taken into careful consideration by all therapists across all modalities especially in the case of intersubjective work with psychosis where issues with sense-of-self-transformations prevail for both clients and therapists.

6.3.2 Implications for supervision and training

Even though clinical supervision is generally considered to be part of a reflective and ethical clinical practice across all therapeutic modalities and client groups (BPS, 2010), in the case of working with psychosis I suggest that it includes even further pivotal support for the therapist. Considering the destabilisation of participants' reflective capacities, a safe and reflective supervision space may be critical for cultivating the recovery of understandability of the client's psychotic experiences, and the in-between intersubjective therapeutic processes appear to consist of a pivotal condition for this kind of work. The provision of specialist supervision sensitive to intersubjective processes is considered fundamental in order to allow therapists the space to share and process the strong cognitive, emotional and embodied responses towards their clients. Supervision must, therefore, place a particular emphasis upon therapists' self-processes, which can foster a mutual communicative platform between client and therapist. Since the ruptures of relatedness are thought of as an inextricable part of therapeutic work with psychosis, which affects the therapist tremendously, perhaps also supplementary support additional to standard supervision might be necessary. This might comprise of attendance of specific workshops, group and/or peer supervision through which therapists can exchange experiences and the challenges in their work in an effort to contain their destabilisations and facilitate therapeutic progression. Supervision groups might particularly be an effective way of bringing out and processing therapist's self-experiences that relate to their work with psychosis which brings to the surface intense feelings of helplessness and vulnerability. For instance, a group supervision setting sensitive to Yalom's (Yalom & Leszcz, 2005) group processes such as universality (assisting therapists to appreciate that they are not alone in their

vulnerabilities) and catharsis (supporting therapists to discharge suppressed feelings through disclosures) can be a greatly supportive contribution to their work and help them to recognise and accept their vulnerabilities and intersubjective complications as inevitable conditions of their work. Moreover, considering participants' emphasis on the powerful role of boundary crossings in their work, it is suggested that supervision must provide the appropriate space for reflection on the nature of dual relationships and boundary concerns by assisting the therapists' self-reflective awareness especially in those cases when boundaries become blurred.

In light of the current findings, it also appears sensible to address some sensitive issues regarding the curriculum of CoP and provide some recommendations for training purposes. Considering CoPts' increasing interest in getting involved with psychosis in research and clinical terms, training courses can play a key role in promoting trainees' interest in this arena and cultivating a climate that will encourage trainees to work with severe distress. This is also echoed in the results of Larsson's (2010) discursive analysis on CoPts' experiences in working with psychosis, in which CoPts considered their training courses as not nurturing their confidence in working with psychosis. Considering that training courses place particular emphasis on intersubjective and relational issues and this particular prominence is exactly what appears to be significant in the therapeutic work with psychosis, training courses must, therefore, develop curriculums that are more sensitive to therapeutic work with severe distress, while they can also provide their trainees with relevant placement opportunities.

6.4 METHODOLOGICAL CONSIDERATIONS AND LIMITATIONS

Even though the current research has offered a useful account of CoPts and psychotherapists' experiences of working with psychosis, it is recognised that there are a number of limitations to the research which need to be contemplated. This section of the chapter will deal with methodological reflexivity and attempt to provide remarks regarding the projects' limitations.

First and foremost this has been my first experience in conducting an IPA project and because of this I struggled with my confidence throughout the research process. Research supervision has been vital in this regard as it has provided an essential space for reflection and encouragement. At this final stage of the research process and upon reflection, I feel that I would have preferred to conduct certain features of the research differently, particularly regarding the interviews. Even though my experience of interviewing participants has been deeply affecting, having had more experience in conducting IPA semi-structured interviews could have assisted a deeper engagement with participants. I, therefore, assert that a lack of confidence has influenced my interviewing attitude. For instance, being overly concerned about suspending pre-conceptions, I sometimes missed opportunities to carefully share with participants, personal and similar experiences to those they had shared. There were certain moments in which if I had attempted to, such disclosures could have perhaps assisted the intersubjective flow of the interviews in a way that could have provided a deeper access to participants' experiences and felt-sense.

Although the sample was represented by a broad range of settings from which participants gained their experiences and included both male and female practitioners and also a representation of several theoretical perspectives, some noteworthy limitations must be reflected. Firstly, all participants in the sample were Caucasian and therefore it can be argued that the sample was not representative with regard to culturally varied perspectives. It would have been interesting to investigate non-Western perspectives on intersubjective approaches to psychosis considering the possibility that non-Western cultures might hold different views on mental health. For instance, a three-decade long international research conducted by the World Health Organisation (Hopper, Harrison, Janca, & Santorisu, 2007) has revealed that people with a diagnosis of schizophrenia in developing countries tend to do better in the long term (fewer admissions, being employed, social communities participation etc.) compared to people in developed countries. The study concluded that the tight social networks in the developing countries include the person with psychosis as an essential part of the community. Intersubjectively speaking, it seems therefore that people in developing countries are assisted in retaining their subjectivity as opposed to developed countries where the person with psychosis is often stigmatised, considered

defective and remains often unemployable. Therefore, practitioners originating from developing countries could have enriched the data with alternate perspectives on psychosis and its therapy.

Moreover, another limitation that relates to sample issues concerns the selection criteria. Despite the screening process that took place in order to ensure that all participants met the inclusion criteria, all participants were self-selected and all identified themselves as working intersubjectively with psychosis. As results have revealed, despite the challenges inherent in their work, the positive nature of their descriptions implied positive and significant experiences through their work with this client group. However, perhaps other practitioners, who also work with psychosis and describe their approach as mainly intersubjective, might be less enthusiastic about their work with psychosis and hence are not represented by this project.

Another significant limitation concerns how much participants' experiences were captured through the medium of language. In an attempt to explore this complicated theme, I provide a brief theoretical reflection and then move into the particulars of my research experience. Although an interview itself can be simplistically described as a linguistic event, I suggest that communication, intersubjective and embodiment processes – fundamental parts of the overall interview process – cannot be strictly reduced to a behavioural-verbal exchange merely mediated by language. Instead, language is a more complicated medium and as Gadamer (1960/1996, p.469) has suggested language is "(…) a medium where I and the world meet". When a person is describing her experience through language, we cannot therefore consider that the use of language in these terms is comprehensively descriptive of her own and other experience. Taking a Heideggerian route, I suggest that language is rather a section of that subjective experience. Therefore, the manner in which language is used does not limit its utility in representing, describing or reflecting an inner or outer world but instead, and according to Heidegger (1926/2001), it partly 'unconceals' being itself since being can never be fully realised, completely revealed or unconcealed.

Taking into consideration these limitations of language, the researcher is therefore recommended to turn her attention towards the intersections between the body and speech in order to gain better access to participants' experiences. Merleau-Ponty's understanding of '*parole parlante*' (speaking speech) in *The Visibile and the Invisible* (Merleau-Ponty, 1968) appears pertinent here. In approaching the complicated processes of language, he understood and described speech as embodying our challenges in attaching meaning to our experiences in the process of self-reflexively communicating these experiences to self and others. He therefore asserted that body and language are tightly conjoined, which has significant implications for interviews that are interested in accessing a person's lived experiences. Regarding my own journey in the research process, I have realised with the completion of data analysis that I could have paid more attention to participants' and my own embodiment processes during the interviews. Even though I often invited participants to reflect on their felt-sense during their interviews in an effort to appreciate their experience more fully, and tried as much as possible to capture their non-verbal communications in the analysis of findings, I consider that this attitude could have been more fully employed. I sometimes struggled to decipher participants' symbolisations in their descriptions of their experiences and have later thought that inviting them to turn towards their embodied situatedness and engagement during the interview could have assisted this process. I also consider that this limitation concerns IPA as methodology overall since its attention towards the embodied can become more comprehensive, despite its commitment to and incorporation of a Merleau-Pontian philosophy. My experience of IPA as a novice phenomenological researcher has therefore demonstrated that the methodology itself could not facilitate a detailed enough attendance towards the intersubjective context within which embodied communication between participants and myself took place, which is in line with criticism that IPA has received in recent years (e.g. Murray & Holmes, 2014). This impression was further reinforced by an additional emphasis that was paid towards the intersubjective processes between participants and myself, considering that interviews took place through videoconferencing and that exploration of embodied subjectivity emerging through videoconferencing was considered significant. Additionally, perhaps the explorations of embodied subjectivity emerging through videoconferencing were not adequately addressed in this study. Despite the good

working alliance throughout videoconferencing with participants evident in the development of results but also in their feedback during the debriefing process, possibly a more thorough and methodical approach towards the exploration of the implications in online interviewing could have been addressed. I therefore also suggest that IPA researchers should be more sensitive towards the incorporation of the focus on participants' bodily experience (e.g. employing Gendlin's 'focusing' method, 1996) since IPA seems to be lacking a more detailed approach towards the embodied and the felt-sense. As Murray and Holmes (2014, p.18) suggested in their critical appraisal of IPA, "(…) our impression of the IPA literature was that the body itself is often absent, or simply presumed to exist behind straightforward descriptions". Therefore, results have only reflected and captured a part of participants' experiences and I accept that the methodology employed could not reach the full richness of their experiences. Along these lines, some novel phenomenological research has recently been presented which suggests that to attain the richness of human experience, researchers should investigate the employment of multimodal means of data collection and analysis. Boden and Eatough (2014) in their expanded version of hermeneutic-phenomenological research suggest that a comprehensive exploration of an experience must also acknowledge and explore its sensory features, thus constructing a more accurate description and interpretation of the phenomenon under investigation. The researchers' multimodal approach suggests the employment of three dimensions of sense experience: the felt-sense, the aesthetic aspects of language and visual imagery. In their exemplary demonstration of their multi-modal approach (an emphasis towards metaphors, analogies, imagery and employment of drawings) towards the explorations of experiences of guilt, the researchers illustrated how concealed fragments of their participant's experiences were encouraged to surface and assisted the elucidation of the guilt-experience in its wholeness. Therefore, a similar multimodal approach can be employed in future explorations of intersubjective approaches to the psychotherapy of psychosis, particularly in an effort to explore more fully therapists' strong emotional reactions towards their clients.

6.5 SUGGESTIONS FOR FURTHER RESEARCH

The discussion of results and methodological reflections indicate certain areas that may merit further investigation in both the fields of CoP and psychotherapy. As has been already stressed, there is a dearth of research in the field of CoP on relational approaches to psychosis; however this has been partly expected considering the fact that since CoP's establishment as a profession, only a small minority of CoPts has been therapeutically involved with this client group. However, the fact that recent years have witnessed an increasing number of CoPts working with psychosis points towards the expectation of further research attempts to investigate in more detail the intersections between CoP and psychosis. More specifically, what has been particularly neglected in recent literature and deserves further research are phenomenological explorations of therapists' subjective and intersubjective involvement and how these can inform the therapeutic process.

Considering the increasing numbers of CoPts working in medical and psychiatric settings, it may be useful to explore CoPts' views on how their work with psychosis is evolving in these settings and how their contributions are perceived within their multidisciplinary teams. Additionally, future explorations of CoPts' perceived professional identities would merit further research in an attempt to explore possible shifts in their perceptions and related processes, and how these possible shifts affect their clinical work. Future research could also investigate what is happening on an international level regarding intersubjective approaches on severe distress from a CoP perspective and how the profession's identity is succeeding outside the UK.

This study was exclusively interested in exploring therapists' experiences of therapeutic and intersubjective processes in their work with psychosis. The clients' perspective was not therefore incorporated. A more inclusive approach towards the understanding of intersubjective processes could incorporate a synchronous exploration of clients' parallel experiences and hence future studies could concentrate on exploring both therapists' and their clients' perspectives to allow a deeper examination of the impact of an intersubjective approach on the therapeutic praxis. As Larkin, Boden and Newton (2015) have suggested, approaching and making sense of

service users', carers' and professionals' views is vital in order to joint these groups with the scope to "co-design" possible improvements.

Participants who took part in this project are therapists who approach psychotic phenomena in comprehensible terms and have strongly differentiated themselves from the stereotypical conceptualisation of psychosis as an incomprehensible state. This evolving perspective that is based on the significance of meaningfulness challenges an assumption of incomprehensibility and points towards the possibility for recovery with possible implications for the client's processing of internalised stigma. A great deal of research suggests that people diagnosed with psychosis internalise social stigma and experience discrimination caused by their diagnosis (e.g. Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002). Therefore, future research could focus on the exploration of the intersection between intersubjective approaches and the impact these might have on clients' apprehension of stigma by recognising the possible shifts in the range of strategies employed by persons diagnosed with psychosis to ward off social stigma.

Considering the powerful impact certain clients' experiences caused on participants and their significant responses towards these, future research could also explore in more detail how clients' particular experiences (e.g. delusional and hallucinatory states) impact on the practitioner and how the nature of these impacts inform particular therapeutic responses. Considering participants' expressed cognitive and affective transformations when attuning to clients' emotional states, it is therefore suggested that further research could explore in more detail the processes of affect exchange based on an intersubjective understanding. Moreover, another important aspect that seems to have greatly affected participants' experiences and merits more research concerns the effect of settings. Taking into consideration how participants' experiences of their therapeutic relationships were considered greatly affected by their settings, further research could also explore in more detail how particular services and settings affect the relational dynamics and therapeutic outcomes.

Lastly, taking into consideration the employment of video-conferencing interviews in this project that proved to be an effective mechanism for data

generation, some further research can be conducted regarding the effectiveness of the employment of videoconference in qualitative research, across diverse research participants and topics. It seems that very few studies employ videoconferencing as a primary research method, which can serve as an alternative, practical and cost-effective method to more traditional face-to-face interviews. Research is needed in order to shed light on how and when to employ videoconferencing in qualitative research by paying attention to particular procedures and considerations and also a deeper exploration of the development of rapport and cooperation between researchers and participants. Some of the important aspects which seem to have positively contributed towards the generation of rich data in the case of this project point towards the initiation of pre-interview communications with participants in an effort to reduce the sense of relative anonymity and affirm their familiarisation with the medium of Skype. Moreover, my sensitivity towards the non-verbal cues and embodied expression of participants assisted the development of rapport while it provided me with valuable information regarding participants' experiences during the interview, which in turn assisted the analysis of results. I suggest that all these dimensions require further investigation especially in cases where participants from a more vulnerable position are recruited and will be disclosing difficult experiences.

6.6 PERSONAL REFLEXIVITY

At this point, I would like to share some personal reflections that have emerged in the process of developing the discussion chapter with the reader. As has been already stressed, the consideration of reflexivity has been of vital importance throughout this project. However, despite the aforesaid emphasis, I must admit that at times I have struggled with how much personal reflexivity I should incorporate in the text throughout the different phases of the project. My frequent ambivalence was mainly related to the dilemma of how much of my own personal accounts I was ready to share without overly biasing the results and also without excessively exposing potential personal vulnerabilities. A significant vulnerability which surfaced through my engagement with the project relates to the insight of how my professional and research interests in psychosis have both been shaped by a personal struggle for

connectedness with others and an attempt to overcome isolation, particularly during early adulthood. Moreover, having not conducted qualitative research in the past and writing from the first person perspective being greatly unfamiliar to me, these challenges proved to be more uncomfortable than comfortable, which also contributed to my experience of ambivalence. Moreover, reflections on my relationship with the project itself brought to the surface the recognition of a common denominator between participants' descriptions of their clients' experiences, their own therapeutic experiences and my experience of relating to the research process, which all seem related to the dynamic of oscillating between the need for merging and separation. Similar to participants' experiences of a constant negotiation between proximity and distance in their therapeutic relationships, I often became aware of my own oscillations between proximity and distance, which manifested in the felt need to keep a distance from the data before moving to the next step. Again, similarly to participants' experiences, the distance has proven to be effective in terms of assisting my reflective capacities. The intensity of participants' reflective difficulties that has been described as an inescapable phenomenon in their work with psychosis has therefore manifested as an inextricable phenomenon in my own process of constructing this piece of work at several stages of the research process. I assume that the manifestation of these dynamics not only points towards the proposition that these parallel processes have resulted because of a common commitment and passion for the phenomena under investigation for both myself and participants on a powerful platform of mutuality and co-construction of meaning, but also suggest that my intersubjectively informed interpretations of participants' experiences were closely related to our quality of relatedness and connectedness. Moreover, it points towards the Merleau-Pontean assertion, which Zahavi (2001, p.241) beautifully describes, and suggests: "(…) subjectivity is not hermetically sealed up within itself, remote from the world and inaccessible to the other. Rather, it is above all a relation to the world, and Merleau-Ponty accordingly writes that an openness toward others is secured the moment that I define both myself and the other as co-existing relations to the world".

CHAPTER 7: CONCLUSION

To my own knowledge, this is the first phenomenological research that has been conducted from an E-P CoP perspective that focuses explicitly on practitioners' subjective experiences in their intersubjective work with psychosis. From a phenomenological angle, I have attempted to shed light on complicated intersubjective dynamics in therapists' processes of their negotiation of psychotic otherness in the therapeutic scenario. The exploration of therapists' experiences in engaging with clients' otherness demonstrated their emphasis on the intersubjective dynamics in the space in-between and showed the deeply affecting nature of their therapeutic relationships on self-experience and other-experience. Despite the destabilisations and perplexities involved in therapists' lived experiences in the space in-between (disruption of reflective capacities, ruptures in relatedness and intense cognitive and affective transformations), their deeply caring attempts to meet clients' otherness with curiosity and respect, have not only emphasised that interaction with clients' otherness involved them in a transformed appreciation of their otherness, but also highlighted how clients' otherness provided them with an opportunity to surprise themselves and revisit their sense of self by revealing aspects of themselves of which they had previously been unaware. Merleau-Ponty (1962) considered this transformative interaction between self and other to be fundamental in his strong opposition to the assumption of an absolute dichotomy between self and other. The other according to Merleau-Ponty intrudes upon the self not only because identification is already assumed but also because the other's otherness is that which has the power to produce change within the self. Despite space restrictions limiting further, more detailed, explorations of intersubjective processes, I am convinced that a close reading of this thesis could act as a catalyst for further dialogue about the use of intersubjective approaches in therapeutic work with psychosis.

In a broader sense, this project suggests that the tight association between the other's otherness and our sense of self are understood as a mutual determination and definition of each other, which dismantles the assumption of their in-between barriers providing 'immunity' and an opening to the 'irrational' or 'psychotic' subject as the

epicentre of the subject of the signifier. In other words, the Otherness becomes the mirror of our temporal sense of self, which is embodied in the gaze of the Other as a form of identity within us. The results of this project suggested that as therapists we must keep our clients' otherness in sight as the absolute priority of our therapeutic endeavours. The essential questions about our clients' otherness must attach meaning in the dialogues we hold with our own selves since our reflections on our relationship with the Other manifests our very relationship with our selves.

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APPENDICES

Appendix I: Project's Ethical Approval

NSPC
NEW SCHOOL OF PSYCHOTHERAPY AND COUNSELLING

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admin@nspc.org.uk
www.nspc.org.uk

Prof. Emmy van Deurzen – Principal
Prof. Digby Tantam – Deputy Principal

Mr Andreas Vassiliou
Sawa Rotsidi 7
Flat 203
Dasoupoli
Strovolos
Nicosia
Cyprus
2014

9th January 2014

Dear Andreas

Re: Ethics Approval

We held an Ethics Board on 5th November 2013 and the following decisions were made.

Ethics Approval
Your amended application was approved by Chair's action.

Please note that it is a condition of this ethics approval that recruitment, interviewing, or other contact with research participants only takes place when you are enrolled in a research supervision module.

Yours sincerely

Prof Digby Tantam
Chair Ethics Committee
NSPC

Appendix II: Project's Advertisment

RESEARCH PROJECT: VOLUNTEERS NEEDED

RESEARCH CONDUCTED BY ANDREAS VASSILIOU, COUNSELLING PSYCHOLOGIST IN TRAINING

The research aims at exploring **Psychotherapists'** and **Counselling Psychologists'** experiences of working either in their private practice or in a different context and on a one-to-one basis with individuals experiencing psychosis. You must be an English speaking qualified Counselling Psychologist (registered with the BPS and HCPC) or Psychotherapist (registered with the UKCP) or both. You must also consider the therapeutic treatment of individuals that have been diagnosed with psychosis as the relational encounter rather than anything else.

It is important to be elucidated that interviews will exclusively take place through Skype by employing both a microphone and a camera.

The research project has received full ethical approval by NSPC and Middlesex University ethics panel and is supervised by
Dr Rosemary Lodge (**rosemary.lodge@virginmedia.com**) &
Dr Andy Fox (**andyp.fox@gmail.com**)

Contact details for participation: **andreas.vassiliou.research@gmail.com**

Appendix III: Participant Information Sheet

Participant Information Sheet

Study Tittle: The I-Thou intersubjective arena of the psychotherapy for psychosis: An Interpretative Phenomenological Analysis of counselling psychologists' and psychotherapists' perspectives of working with psychosis

Being carried out by,

Andreas Vassiliou

As a requirement for a *Doctorate in Existential Counselling Psychology* from NSPC and Middlesex University.

NSPC Ltd
258 Belsize Road
London NW6 4BT and Middlesex University

Dated: 03/09/2014

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

1. What is the purpose of the research?

This study is being carried out as part of my studies at NSPC Ltd and Middlesex University. The proposed research aims to explore psychotherapists' and counselling psychologist's intersubjective experiences of working therapeutically with individuals manifesting psychotic symptomatology. There has been considerable emphasis in psychotherapeutic and psychological literature on the distortions of intersubjectivity in psychosis and its prodromal states and many mental health professionals view within the relational frame of the clinical encounter the manifestation of such distortion. However, there has been little conceptual bridge building between therapists' and psychologists' experiences of self and other when working through a dialogical-intersubjective manner with clients diagnosed with psychotic disorders and the impact on the therapeutic process. In order to investigate this further we need to explore a phenomenological account based on individual meanings attached to intersubjectivity as constructed by therapists and psychologists who have had experience in working therapeutically on a one-to-one basis, with individuals diagnosed within the schizophrenic spectrum. In-depth semi-structured interviews will be employed to explore clinicians' experiences and understanding of intersubjective encounters and the meaning they attach to these experiences. The interviews will be analysed using Interpretative Phenomenological Analysis (IPA). You are being asked to participate because you have replied to the relevant advertisement to volunteer for this project.

2. What will happen to me if I take part?

You will be interviewed on one occasion and the interview will be conducted through Skype on your own convenient date and time. The semi-structured interview will take about an hour and the information gathered from the interview will be analysed by the employment of Interpretative Phenomenological Analysis methodology.

3. What will you do with the information that I provide?

I will be recording the interview on a digital recorder, and will transfer the files to an encrypted USB stick for storage, deleting the files from the recorder. All of the information that you provide me will be identified only with a project code and stored either on the encrypted USB stick, or in a locked filing cabinet. I will keep the key that links your details with the project code in a locked filing cabinet. For the purpose of your anonymity protection, your name will not appear on your data sheets/files and a coding system will be introduced to identify you, in case this should be necessary. In the attached consent form you are informed that in the case you agree to participate in this study, excerpts from your data may be published verbatim as anonymous example. Moreover, data will be kept stored on a computer with password known only to the researcher and you will be allocated a pseudonym of your own choice. The information will be kept at least until 6 months after I graduate, and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used. Data will be stored according to the Data Protection Act and the Freedom of Information Act.

4. What are the possible disadvantages of taking part?

During your interview, you will be asked several questions with regards to your relational/intersubjective experience of working with clients that have been diagnosed within the schizophrenic spectrum. Talking about personal experiences may sometimes be distressing for certain participants. If so, please let me know, and if you wish, I will stop the interview. Also, although this is very unlikely, should you tell me something that I am required by law to pass on to a third person, I will have to do so. Otherwise whatever you tell me will be confidential.

5. What are the possible benefits of taking part?

As it has been mentioned earlier, there has been little conceptual bridge building between therapists' and psychologists' experiences of self and other when working through a dialogical-intersubjective manner with clients diagnosed with psychotic

disorders and the impact on the therapeutic process. The benefits of taking part in this study might not be direct, but it is possible that it will be beneficial for the professionals within counselling and psychotherapy dealing with clients experiencing psychosis and therefore for their clients. Moreover, being interviewed about your experience as a therapist/psychologist might provide you the opportunity to reflect on your clinical practice and professional and ethical stances within the discipline of counselling and psychotherapy.

6. Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins. Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason. If we decide that we will be using Skype for the purposes of conducting the interview then consent form will have to be signed and returned to me prior to the interview either via fax, through the post or it can also be scanned and sent via e-mail.

7. Technical issues

Since the quality of digital recordings using a separate recorder during Skype videoconferencing may not be clear, computer-based recording software will be employed which integrates into Skype and records the audio mode. It is important to specify that only audio recording will be employed for this study.

8. Pre-interview communication

It is considered as vital to arrange a pre-interview online meeting in order to include an assessment of the experience and comfort level with the selected technology (i.e. Skype). If you do not feel very comfortable with Skype, a time will be arranged when we can meet online using the interview technology as part of the preparation.

9. Emergency concerns

In the case of having to deal with an unfortunate emergency situation happening to you during the interview (e.g. physical injury, accident) I will need to have access to emergency resources located near where you are located, such as a significant other or the local police department. This necessitates that your full name and surname and location are known. It is also significant that you make sure that a significant other is informed about the date and time of the interview, but also where you will be located.

10. Who is organising and funding the research?

This research is organized by myself in collaboration with my primary and secondary research supervisors and it is funded exclusively by myself.

11. Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee has fully approved this study.

12. Expenses

Since the interviews will be conducted exclusively through Skype, there are no specific expenses relating to participants' recruitment.

Thank you for reading this information sheet.

If you have any further questions, you can contact me at:

New School of Psychotherapy and Counselling
254-6 Belsize Road
London NW6 4BT
Andreas.vassiliou.research@gmail.com **or** vassiliou.andreas1@gmail.com

If you any concerns about the conduct of the study, you may contact my primary supervisor:

Dr Rosemary Lodge
New School of Psychotherapy and Counselling
254-6 Belsize Road
London NW6 4BT
rosemary@nspc.org.uk

Or

The Principal
NSPC Ltd. 254-6 Belsize Road
London NW6 4BT
Admin@nspc.org.uk
0044 (0) 20 7624 047

Appendix IV: Background Information Sheet

BACKGROUND INFORMATION

The following information will be used for qualitative purposes (i.e. to indicate the quality and level of this study). All information will be treated confidentially. Nevertheless, if you don't want to answer some of these questions, please feel free not to.

1. Are you *(please tick the appropriate answer)*

Male __ Female __

2. How old are you? [ ] years

3. How would you describe your ethnic origins? (*Please tick the appropriate category)*

(a) White
* British __
* Irish __
* Any other White background _____

(b) Mixed
* White and Black Caribbean __
* White and Black African __
* White and Asian __
* Any other mixed background_____

(c) Asian or Asian British
* Indian __
* Pakistani __
* Bangladeshi __
* Any other Asian background _____

(d) Black or Black British
* Caribbean __
* African __
* Any other Black background _____

(e)Chinese or Other Ethnic Group
* Chinese __
* Other Ethnic Group _____

6. Are you *(please circle)*

Counselling Psychologist, Psychotherapist, Both

7. Years of clinical practice post qualification?

_____

8. How would you describe your therapeutic orientation (*Please Circle)*

Integrative Pluralistic Psychodynamic Psychoanalytic Person Centred
Cognitive Behavioural Existential

Other (*please specify)* _____

9. In what particular setting have you worked with this client group and for how long?

_____

Appendix V: Informed Consent Form

Middlesex University School of Health and Social Sciences

Psychology Department

Written Informed Consent

Title of study: The I-Thou intersubjective arena of the psychotherapy for psychosis: An Interpretative Phenomenological Analysis of counselling psychologists' and psychotherapists' perspectives of working with psychosis

Academic year: 2013-2014
Researcher: Andreas Vassiliou

Supervisor: Dr Rosemary Lodge

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I understand that the interview will be audio-recorded solely for the purposes of the research study as described in the Participant Information Sheet.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

_____ _____

Print name Sign Name

Date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

Appendix VI: Debriefing Form

Debriefing Form

For the Study entitled:

"*The I-Thou intersubjective arena of the psychotherapy for psychosis: An Interpretative Phenomenological Analysis of counselling psychologists' and psychotherapists' perspectives of working with psychosis*"

Dear participant,

We would like to thank you for taking the time to participate in this research project. If you have any concerns about your participation or the data you provided in light of this disclosure, please don't hesitate to discuss this with us. We will be happy to provide any information we can to help answer questions you have about this study. If your concerns are such that you would now like to have your data withdrawn, we will do so. Moreover, if you feel distressed for any reason because of your participation we will be able to offer a second meeting to discuss any issues and concerns that came up for you.

For any questions and concerns about your participation in the study, please contact me at:

Andreas Vassiliou
New School of Psychotherapy and Counselling
258 Belsize Road
London
NW6 4BT
andreas.vassiliou.research@gmail.com **or** vassiliou.andreas1@gmail.com

Or my primary research supervisor at:

Dr Rosemary Lodge
New School of Psychotherapy and Counselling
258 Belsize Road
London
NW6 4BT
rosemary@nspc.org.uk

Please again accept our appreciation for your participation in this study.

Appendix VII: Interview Schedule

1. **Thank you very much for participating in this study, as you have read in the information sheet, I am investigating practitioners' experience who work with psychosis from a relational/intersubjective vantage point. Shall we start by what attracted you to this research topic?**

2. **From your own clinical experience what is your understanding of psychosis both conceptually and in terms of clinical presentation?**

3. **What does it mean for you working relationally with this client group?**
   Possible prompts: Experientially? Conceptually? With regards to clinical interventions? Can you please give me some examples?

4. **What is the role of the therapeutic relationship when working with this particular client group?**
   Possible prompts: What kind of feelings emerge for you? Can you describe moments of connectivity? Empathy? Can you give me an example? Are there any particular difficulties? Can you think of an example demonstrating these difficulties? How do you handle these?

5. **Given the relational emphasis of your therapeutic work, how do you use (if at all?) the space-in-between?**

6. **Can you describe the ways in which you are impacted when working with this client group?**
   Possible prompts: Are there any particular feelings emerging? How do you understand them? On a physical-embodied level? How do you feel in yourself after a session? Is this in any way different from working with other clients?

7. **Is there anything else you would like to add which is of personal importance to you when working with these clients?**
   Possible prompts: On an emotional/thought level

Appendix VIII: Paula's original transcript

TRANSCRIPT NOTATIONS

(P): Significant pause
(p): Brief pause
[redacted]: Real name (person, organization, setting, etc.) omitted to safeguard anonymity
[redacted]: Information omitted to safeguard confidentiality

ORIGINAL TRANSCRIPT

R1: Hi [redacted] nice to see you here. Thank you very much for taking the time to participate in my research.

P1: Thank you. It's my pleasure. Hold on fixing the camera. Small complications but I should be fixing that in seconds.

R2: Take your time.

P2: Right all set now.

R3: Well obviously because English is not my mother tongue, if you find difficulties in understanding what I'm saying or if I'm not clear, just ask me back.

P3: That's fine

R4: Right, I've received your background information sheet. Sorry for sending it last minute, I forgot it. So…one of the things you didn't complete was your orientation.

P4: Oh. I must have missed that. Well I guess primarily I see myself as an integrative therapist. I use some CBT; I particularly like some narrative therapy ideas, certainly with the sort of client group that I work with its mostly integrative really.

R5: OK

P5: Yeah

R6: Well. As you've read in the information sheet I am interested in exploring how therapists or counselling psychologists work with psychosis from a relational and intersubjective vantage point. Just to start, what has actually interested you in my research topic?

P6: Emm, I guess that I don't know many counselling psychologists that specialize in working with psychosis or trained to take that as a speciality so I think that some of the skills that we have are a strength really in working with the group of people I work with because we are able to engage people well. We have a lot of skills of just being present for clients that I think enable you to sustain a relationship when it's very difficult. So I've always felt like that, and yeah but I don't see many counselling psychologists do what I do. So I suppose I wanted to support, more of the interest of that in terms of the research as well really.

R7: OK. So from your own clinical experience what is your understanding of psychosis, I mean both conceptually and in terms of the clinical presentation of the clients?

P7: I guess I describe it as a sort of breaking down of stories of experiences in some ways, disintegration of somebody's thoughts, sense of identity but also the being, as someone having lost touch with reality in that process as well. Yes, if that's a simple explanation for such a complex thing. Yeah, I think that's how I see it.

R8: You said disintegration. What do you mean by that?

P8: Emm, an inability to make meaning. From, possibly from, through past experiences, or through, perhaps there has been trauma. Emm, in that a person is unable to sort of confront on an emotional level but also cognitively make sense of those experiences. There is too much for them to cope with, in a sort of, emm, reality based way. And sometimes that meaning becomes more apparent for someone with psychosis.

R9: Ok. And what about the sense of identity you have mentioned? What happens there? How do you see that?

P9: Emm, I guess there is a very disrupted sense of self. Sense of identity really that people are lacking, a coherent story about themselves, who they are, apart from those experiences. And often is very hard to get to that in working with people. Often is something that, you know its genuinely really working when the client it's on their first interview and you are thinking about what, well when I start to see somebody who are recognizing who they are as a person it probably means that we've gone quite a long way when that really happens.

R10: In what way?

P10: [p] I suppose is about them being present with themselves and their own potential for growth, to take care of themselves, to be responsible for themselves, and not to sort of being stuck [p] in a sort of psychotic process whether that's about fantasy or denial about experiences however way that psychosis might function for someone. You know, it can function in different ways for people. Perhaps in terms of how it has come about and I don't know if I can always work that out. I am not sure if that answers your question?

R11: So you see from what I'm hearing from your own clinical experience psychosis manifesting in different ways in different clients. Is that what you said?

P11: Yeah. Yeah very much so. I guess I am trying to think through different cases in terms of how I can understand how someone's psychosis has developed like. For some people substance misuse it's a huge element, some people it seems clear that there is a more biological connection, other people there is much clearer link to child trauma and neglect, but it's easy from my perspective often easier than it is for me than for them to understand how it has been difficult for them to sort of developing a cognitive map of the world really and how to make sense of it. [P].

R12: And are there any other prominent clinical manifestations or symptoms that you have in mind in reference to the clients that you have in mind that are common?

P12: Certainly the way that I see that are not being able to construct meaning out of the psychosis experiences, so explicitly on psychosis but also of their sense of self or past experiences that they may had and not sort of linking back together again. And perhaps in some cases that being quite functional perhaps about not being able to face past trauma and to cope with this sort of affective experience of confronting that, but in other cases it perhaps be more about just a simple break down of the ability to make sense of things that might be more biologically drives rather than psychologically. But I guess there is an inability to construct a coherent story that they stick to that, make sense of and hold on to and move forward in life.

R13: Hmm. As you have mentioned you have a more relational way of working with these clients. What does it mean for you to work relationally with this client group?

P13: I guess is about attachment experiences, I guess I'm always very mindful that for the most part the clients I work with had difficult childhood experiences, breaking attachments that maybe played out in the relationship that they have with me in some way and that's, emm, also not always able to emm for instance work with someone in a cognitive behavioural therapy way might find my approach threatening, they might be not able to challenge their experiences. I am able to offer them a different type of relationship and I see that as having some value really. It's often not about recovery or change in the same way as I see it with other client groups. Sometime is about being there for the client being able to offer a different sort of relationship that they can learn from. I think sometimes there might be an unrealistic expectation that this might be internalized in that they can sort of move forward from their past difficulties and to develop you know, self-care and compassion towards themselves but I see that it helps in a kind of a supportive way which enables them to deal with things in the here and now and to help them deal with some aspects of psychosis rather than to battle with it.

R14: So how, what does it mean for you to work relationally from the experiential standpoint? Regarding your clinical interventions?

P14: OK. I guess it's about, I suppose relationship. Emm it's probably about me sort of [P]. I think I am very aware about judgment from other people and the level of that effect that they have to cope with and sort of manage that in the room with them.

R15: Manage it how, in what ways?

P15: Actually coming back to think about attachments. Sometimes the client has too much and sometimes once we start making some insights and the attachment gets too strong the clients would tend to back off more, avoiding me and me noticing that. With another client group I might be more challenging in terms of working with that, with this client group I might be more aware of it and allow it to happen to some degree by trying to hold something about, about them and what that tells me about
formulation and understanding something about their difficulties, their past that often with some people we might be doing some guess work together whether there was some past trauma there or that it might not be disclosed.

R16: You have mentioned a couple of times attachment. It seems like it echoes the relational thing for you. The relational way you work. I am wondering whether you can recall any particular examples working with a client that attachment, as you understand it became so much that it didn't allow you to work relationally.

P16: Yeah. There are a lot of examples there is it? [p]

R17: Well if you try to focus on one so that we can explore that.

P17: Yes, I can think of a male client that I work with in his thirties. Very long history of psychosis and a lot of risk issues as well being in secure services. Loads of self-harm, command hallucinations that would command him to harm himself and spend most of his life in secure settings. And his engagement with…I work within an assertive outreach team, his engagement with that team it's extremely guarded and they have no, I had very limited information about his experience of command hallucinations so he was very resistant to engage with psychology. But I actually very quickly formed a relationship with him in terms of thinking about...he was actually experiencing relationship problems at the time, in relation to erm cause of anger difficulties, so I was acknowledging kind of forced control and anger problems so he became guarded about psychotic experiences that might have been quite a fact so he was sort of saying that this is also

connected to some problems that I had from long ago that I don't want to talk about. So then actually a huge history of neglect in childhood but he was able to form an attachment and to start to trust me and start working on all of those things. But it felt that it was a huge thing for him to start to open up all of those details so he would...he back off and then he would engage and my team allows the possibility for that, than I am there available. I mean in the team we hold a caseload of 100 clients that would disengage and engage again. So he disengaged and said he didn't want to work anymore but then he wanted to come back in and wanted to reengage with psychology. And it was I guess this was something that we talked not only with me but with the team as well and how he related to the team generally, that he would engage and form relationships and to open up about his experiences and then he pulled back. So it's about sort of noticing that with him but also allow it in a way rather that pushing him and challenging to the degree that he needs to engage, that he has to think of that and that enables him to continue to work with me really. And I suppose I sometimes see working in that context, within that team I am constantly involved in some way, I am still present for some of the clients within my team where I am not necessarily seeing them for weekly therapy sessions or I am still holding them in mind. Enabling them to able to make use of their own defences and to help them reflect on them when the time is right to do that.

R18: What kind of defences do you mean? If you are thinking of that particular client?

P18: Yeah, emm for that example denial, projection, rationalization, yeah splitting. For others there are all sorts like fantasy, not so much for that client but. Yeah.

R19: So let's see all of these because they sound important. So denial, in what way? Denying what?

P19: [P] Denial of…probably reality. Erm and I guess denial in relation to past experiences where they have been significant really.

R20: What about the fantasy part? What kinds of fantasies emerge?

P20: So I wouldn't say so relevant about that particular case. Certainly for others. Fantasy I see it as providing another way to be, to have a sense of being in the world, to have relationships, and often the fantasy is about relationships really. Or. Identity. And particularly with a very complex client I am involved in working with now who I see her as having, and with a lot of other clients, having some personality difficulties as well as psychosis and she often, there were times when she was destabilized by environmental stimulus and stress triggers and things and she often behaves as she is a child. She is very dissociative and the rest of the team would see her as playing games, as being a child. So, playing with imaginary friends.

R21: During sessions you mean?

P21: I am talking about the team generally but she is better able to engage with me. She forms all this formulas, she has the idea that she can create formulas and that God passes these formulas to her for medicines and that will enable her to cure diseases for people and often gets frustrated because it's not possible for her to make this formula for herself to cure her disorder. So that sort of fantasy gives her a purpose, something quite meaningful and important and actually her life has been empty in many ways. She has suffered severe neglect and some degree of abuse although that's not clear, so it's not so clear to work with but loads of attachments difficulties in relationships, family relationships that had broken down, she hasn't been able to maintain a job, so this fantasy is extremely valuable really.

R22: OK. This sounds important. I am wondering how do you work relationally with her with regards to the fantasy.

P22: Sure. So at times I acknowledge it in sort of noticing, I guess reflecting when is there and when is not there. Sometimes is not there at all and so we are able to have very grounded discussions about problems in her life. Other times is really difficult, but sometimes is easy to reflect upon why it would come about at certain times. Or the fact that is real for her.

R23: So when is real for her, because you mentioned earlier about having a grounded conversation when talking about present relationships, so when for example this particular client goes on to talk about relationships that happen in her fantasy how does the relational way you work with her plays out?

P23: [P] She will often call people silly names. There are times when she would say, oh I have seen you earlier today, and I have already had a conversation with you. I spoke with the invisible you. Or there was a time when she called me the pixie lady for about a year. I guess, I think this is a very difficult case and sometimes it's almost impossible to reflect upon these things. I think there is a fine line for this particular lady between personality difficulties and psychosis. And, there are times when there is clear psychosis and other times a borderline personality disorder element in terms of her seeking care. But certainly there is [P] I think there are different ways in which she will be using this fantasy in that relationship and how she understands my role and my own involvement with that. So she might be defending not to get close and also [P] how she sees and makes sense of me.

R24: So how are you finding yourself relating to her fantasies? For example you've mentioned earlier that she would tell you she had a conversation with the invisible you, or I can't remember how you actually said it. How are you finding yourself relating to that?

P24: Erm I think it's been very difficult actually. It's being quite a long time now. Initially I would feel quite uncomfortable with that I think. And I'd find it much more difficult to be present and I would be probably more keen to reflect on my need to pull back from the work and [p] I would be questioning whether there is any value of me being there. I mean whether my presence increases distress rather than help and I'll be struggling with my confidence regarding the interventions. At times I think I've been more able to stick with it and acknowledge actually that this person sort of needs this fantasy and it's not necessarily my job to have to deny it.

R25: So you are saying that at times when she talks about the fantasy you're questioning your presence, you are questioning your interventions and you wonder whether you're helpful towards her.

P25: Yes. So I'll be wondering whether I should be working with this person. Or would it be a better place somewhere else. I'll be frustrated with her perhaps.

R26: Frustrated with her? Tell me more.

P26: [P]

R27: What is frustrating?

P27: Not being able to relate [p]. And not being able to make sense of her really. I mean, I have a formulation, but there is too much there to make sense of. There is too much discontinuity and it's impossible to put the links back again and that she has a coherent sense of self or how I would like her to have.

R28: Ok. So when you are finding yourself getting frustrated, how does your frustration or any other difficult feelings you have, affect the therapeutic relationship if at all?

P28: Erm [P]. I think it makes me back off a bit. Probably, erm even to a degree, it might sound extreme but sort of dissociate a little bit. I guess I see myself from as her. Finding it very difficult to make sense of what I am sort of seeing. I guess I feel something's thrown at me.

R29: And you say you're dissociating.

P29: Well that's an extreme term isn't it? I'm not that present with her. Because that's too much. And that's what exactly is for her. But I think it's very difficult to find the space to make sense of that.

R30: OK. So in that situation, in that process of trying to make sense and becoming frustrated what else happens in the process to reach the narrative, to reach the client?

P30: In terms of the relationship process on its own or in terms of my interventions?

R31: I think both sounds important.

P31: Well sometimes there is a natural disengagement. At times there's been an admission to the hospital. [p]. I think I've been aware for this person that I have been discussing in supervision recently that erm we have constructed a plan together that we will reduce the frequency of our sessions and I found myself reflecting back if it was the right thing to do really or if I was getting pulled in sort of abandoning her in some way, or rejecting her or avoiding her. Because you see, what was difficult for me was needing to have an intervention really needing to do something in our meeting so that it would be valuable for the NHS. So working with evidence in a way, and having confidence about that. So there is a need to force something, to do, do to her, to feel that therapy is more constructive. And doing the sense making when she is allowing the sense making really.

R32: You have mentioned a couple of times the disengagement from your side. And I'm wondering how you handle the emotions of disengagement when you are with the client.

P32: Are you talking about the disengagement in the room?

R33: Yes, in the room with the client.

P33: Well it's difficult really. I mean for the most part, I tend to think of my role in the NHS really and it can just be totally confusing. Exhausting. I recently receive more of psychodynamic supervision because I have been supervised for a long time from a CBT perspective and not from long-term psychotherapy approach supervision but that's their main approach and I've realised that this didn't allow me to reflect on this and other things [P].

R34: So what other kind of emotions emerge for you when you are disengaged from the client?

P34: Boredom sometimes, frustration, confusion, anxiety. I think that's the main menu really.

R35: What is the anxiety about?

P35: So, where is this going? And to control it in some way to keep this person safe and whether that's possible. Whether we can sort of, I guess something about things being manageable and not putting things in the way that might be unhelpful. I am feeling quite responsible for that really.

R36: Unhelpful for whom?

P36: Unhelpful for the client.

R37: Can you think of an example? That sounds very interesting. What can be unhelpful for the client?

P37: I guess it's coming back to the fantasy stuff for me actually. Look at it from a more reality based way trying to think about how it functions facing it, the reality of this is a person that hasn't been able to sustain a relationship, and desperate to have children, and substance misuse, and seems unlikely to achieve those things. And there is a huge you know, erm human beings, the majority take this for granted really. Not easy to accept. And by actually being the person that finds the smallest thing difficult to cope with and I guess there is a very fine balance to be able to sort of see these kinds of things and be able to see some meaning and make sense of it, but that too much leading to all sorts of disintegration really.

R38: And talking about meaning how are you finding yourself making meaning or not of their inability to engage pragmatically and on realistic grounds?

P38: It would come up in the process. Noticing patterns, the here and now statements, and what happens between us. So for example I've

noticed that we get pulled in a fantasy, the formulas again. You are sharing with me all those formulas but I'm wondering whether we can reflect on them instead of how they have come about and sometimes we are moving towards me been drown into being in this fantasy, being given a formula and being asked if I can take it on and being able to say 'what just happened there, the dynamics have changed' and then we are talking about something that happened yesterday.

R39: So you are mentioning some challenging issues that are brought up in the sessions. I'm wondering and thinking towards the other spectrum in thinking about the particular client or other clients that you've talked about, moments where you've felt connectivity and proximity with them. If you can describe these moment, how they happen, when they happen, if the happen?

P39: You mean moments where I felt more connected with them? Erm [P]. You know thinking about it I have a great influence over, but often is also erm [p] sometimes with humour, or sometimes it can actually come out of the discussions with them, it comes out of the more human relationship, rather than me trying to employ a diary for them if I am using a CBT intervention. And I guess that brings me back to the difference between being and doing and being aware of that. And being-with allows forming the relationship but with this client group that comes with its challenges because often many difficulties arise in the relationship.

R40: And how would you describe yourself in a being-with mode with a client?

P40: [p] I guess I am more present emotionally in terms of acknowledging the whole person, not just the psychosis so we might not be talking about that. With that I am more present within myself, I bring more of myself to that.

R41: So you are more in touch with yourself.

P41: Yeah. Yeah. Much more.

R42: And how would you describe the relationship between you and the client when you are in that state of being-with with them? How would you describe it?

P42: Much more real. Less of a battle. I guess there is less of a battle for meaning really. I suppose is the difference there between trying to sort of either dissect or change meaning from a sort of CBT perspective. Working with beliefs or questioning delusions or whatever might be. To just being-with, hearing how they make sense, how the client makes sense of things. But often I think if someone's not ready to question or to change meaning they would have got it out in the first place. But again if they might be questioning meaning then this brings us more back to the relationship. So being present there and observing it. And this allows them to be present, I see that they feel not judged and more accepted and feel warmth in the relationship. Humanistic staff.

R43: How are you experiencing the warmth you are talking about? What is it like for you?

P43: [P] I guess it comes up with just the acceptance of things. Much more existential level really. You know really difficult things happen in life and I suppose with that probably my awareness that difficult things happen in my life as well and how do I deal with that. And about being more grounded in that and I think the warmth is also from the position of the awareness of myself and from my own experiences of [P] if that makes sense really.

R44: And how do you feel talking about it now?

P44: It's interesting. Emm, but I guess it feels risky in the work.

R45: Risky in what way?

P45: [P] I guess those things cannot necessarily be fixed, acknowledging that. Erm... that actually you're to meet somebody's life in a very significant way that it's quite a big responsibility really. Especially when you might not be able to do much about it. Erm, other than to be there in some cases I think. Not all. I guess it's an entering into a certain amount of madness really. And that's often a challenge depending on all sorts of settings that you're working in, but you often go back to an environment that it hasn't got much of a capacity to see life on a continuum and acknowledge our own madness. I think being with someone often means acceptance of some of those beliefs you know…people have beliefs that are unusual and unproven and superstitions and myths that they hold on to and they are not pulled in these. And in the rest of my working life I am not religious as a person necessarily, or these huge amounts of customs and actually as a person I sort of resist to that but in my client work I accept it and see that it has value for people but it forces me really to question my own beliefs. If I'm truly present with someone it challenges me.

R46: So, when you are in the mode of being-with the client and you feel the warmth you were describing earlier it seems that you are not only engaged with the other, with the client, but you are also engaged with yourself.

P46: Yeah.

R47: You also mentioned earlier about the settings, how the setting affects the way you work. I am wondering how you think the settings affect your work with this client group.

P47: I mean there are loads and loads of ways. But I guess the main thing that came to my mind really was being in a team where I am the only psychologist. And, they are quickly not valuing the difference in beliefs and form a certain attitude about a client. So I'll be quickly faced with a lot of judgements and appraisals about…someone being controlling, playing games, a lot, and a huge level of anxiety and chaos around whether this person has a psychosis or not. There are times when it is clear that there is psychosis but other times there appears to me that something else is happening. And a certain expectation about what a team should be able to achieve. And how things are making sense. I think I take this as part of my job really. How they are making sense of that and sort of being able to make sense about the team dynamics as well. But sometimes coming to a busy day to see a client that is that complex you are already not really present to yourself. And that has a direct influence on the work really. You can find yourself being pulled into other people's attitudes and ideas about what's happening. The third person being in the room in a way, the psychiatrist, the nurse, the social worker etc.

R48: And that has the potential to affect the therapeutic relationship. Are there any other ways that the therapeutic relationship can be affected by these external influences?

P48: I mean the boundaries issues are big, especially in my team as compared to a CMHT setting or an individual therapy setting where you can manage that. You know to a degree. For example if a client of mine contacts the service, the person that answers the phone might respond in a different way that I would. Recently for example I had a client who contacted the team and mentioned that they had a physical health problem on their grown and the admin staff said why don't you show [redacted] when you see her. And that's how the session started. So different contacts with different people introduce very different boundaries. There is a constant renegotiation about all of that.

R49: And you also mentioned earlier something about the NHS expectations which is more to the side of doing things and be productive. And you described earlier how that affects your own expectations and how you relate to the client. And that sounded important for you. Can you say more about that?

P49: Oh yeah. Yeah. Well I am at a setting where is primarily nurse laid; psychiatric nurses and they have a certain attitude, which is very pragmatic. Focused upon you know, skills, solutions, fixing things, and that's very strong. Often there is a sort of gaze on you, what are you doing, what are you contributing to working with this client or there is a perception that If I was to talk about being with somebody I get laughed at the team at times. And it's quite hard to fight for that. I think alongside pressures, lack of recourses and pushing towards certain pathways and the pressure when there is no improvement from these clients that we might get paid less if we continue to work with them. You know, that is our job to move their mind and if not they will start not paying us or having less resources for these people that are really complex and in some cases you can't expect to get huge results.

R50: So it seems that the gaze of the settings is limiting your work and it's pressurizing you.

P50: Yeah. Yeah.

R51: I was thinking of asking you, given the relational emphasis of the therapeutic work that you talked about, how you use, if at all, the space-in-between you and the client?

P51: In the room [P] I suppose different levels of silence. I guess it makes me think about that kind of attaching and moving away to a degree. I think there is a way in which I support that in terms of how I ground people and at the end of sessions and focusing on something that is reality based and more real. But I am detaching a bit in that, in sort of ending the encounter.

R52: Sorry, so you feel that you are detaching yourself by trying to ground in the here and now?

P52: I suppose my thought was about ending the session and that person is not necessarily going to have that sort of relational depth with me. There is something about ending it and moving into some more superficial topics really and that thing about having that person sort of getting some of their defences back and to be grounded but not exposed.

R53: Exposed?

P53: I suppose what I mean by that is being in touch with some of the difficult feelings that might been felt in one session and about trying to contain that.

R54: You mean difficult feelings for you or the client? Or both?

P54: Both. Yeah.

R55: And where do you think, if at all, difficult feelings of yours and the client's meet? Do they meet?

P55: Yes, occasionally.

R56: Describe me this meeting.

P56: I guess there are moments of reflection and challenge and quite recently I had a quite significant reflection with somebody about them acknowledging how they had a fantasy that I could look after him. And that was sort of a replacement for someone they worked in the past with whom they had a good relationship with and then he experienced the loss, and then that I am not always going to be here and I can't actually do that. That as much as other people have let you down and rejected you I will too. And to be able to sort of sit with that.

R57: And thinking about how you are impacted on any kind of level while working with this clients, I'm wondering how during sessions and if you are impacted on a physical level, on an embodied level.

P57: I guess to a certain degree you know, in thinking about feeling anxious at times or feeling that embodied aspect to that, or feeling lethargic and exhausted, tired.

R58: And how does it feel in your body if you can recall, on moments like the previous ones you described earlier when you disengage and you feel quite frustrated. How does it feel in your body?

P58: Tensed. A feeling of something knocking on my head, restlessness, agitated.

R59: And what happens after a session finishes? Is there anything particular that you feel or is there any particular way you are impacted? How does it feel?

P59: [P] I guess it all feels like leaving one world and going back to another one. Another one which is actually the setting in which not

everybody can understand. Sort of having to re-orientate yourself. And often to make some space for yourself. Particularly with clients that appear disrupted in terms of their thoughts, sometimes it's quite difficult to just go from the one to the next. You need a little bit of time to make sense of all that.

R60: So you are describing a transition from one world to the other, from the session that ended towards the setting, which sounds like a challenging transition.

P60: I guess it's about moving from being to doing.

R61: OK. We are approaching the end. Is there anything you would like to add which is of personal importance to you when you are working with this client group? Any insights?

P61: I think what was interesting as I was reflecting on, was probably the different modalities that I might use. And making sense of that from the relational or the psychodynamic approach and I think sometimes when I start looking for tools and they might inevitably be CBT related tools, because CBT has a lot of tools, more of the doing interventions I wonder if that relates to a, I guess it's another way for me to sort of structure myself and make sense of what's happening but also possibly sometimes another detachment from the being-with. And I guess that's quite interesting if we are reflecting on it in that way. Often it seems very natural and perhaps it's a useful thing to do and bring some of that to my work. But I think it's also helpful to reflect on it really.

R62: So while you were describing it, I had a picture in my mind, you the client and the tools. So you mentioned before that your engagement with the tools might be expressing your disengagement with the client. Is that what you said?

P62: Yeah. [P]

R63: OK. What purposes do the tools serve for you?

P63: They also help me to keep being there. And I was thinking it in with regards to their own defences. They need their defences and I need mine. And sometimes this enable me to, helps me to understand something to make sense of what my role is, in being in the room with them. And it allows me to think of formulation when it comes to this client group because I don't think I could confidently say that my clients that present with a sort of residual psychosis that I have a formulation about and understanding that I am 100% right. I think sometimes these tools, these formulations help me to be able to make sense of the case and to take some meaning from it all. And to sort of be there and have some kind of relationship.

R64: So it's a matter of professional confidence and at the same time managing your own anxiety in dealing with the disengagement from the client as well.

P64: Yes.

R65: Anything else that comes up? Anything prominent in you at the moment?

P65: No, I don't think so.

R66: Thank you very much Paula for taking part in this. Well let me switch off the recorder so that we can debrief.

P66: OK. Thank you

Appendix IX: IPA full transcript analysis for Paula

Emergent Themes	Exploratory Comments	Original Transcript	Descriptive Comments
		R1: Hi [redacted] nice to see you here. Thank you very much for taking the time to participate in my research. P1: Thank you. It's my pleasure. Hold on fixing the camera. Small complications but I should be fixing that in seconds. R2: Take your time. P2: Right all set now. R3: Well obviously because English is not my mother tongue, if you find difficulties in understanding what I'm saying or if I'm not clear, just ask me back. P3: That's fine R4: Right, I've received your background information sheet. Sorry for sending it last minute, I forgot it. So…one of the things you didn't complete was your orientation. P4: Oh. I must have missed that. Well I guess primarily I see myself as an integrative therapist. I use some CBT; I particularly like some narrative therapy ideas, certainly with the sort of client group that I work with its mostly integrative really. R5: OK P5: Yeah R6: Well. As you've read in the information sheet I am interested in exploring how therapists or counselling psychologists work with psychosis from a relational and intersubjective vantage point. Just to start, what has actually interested you in my research topic?	Identifying herself as an integrative therapist with specific reference to CBT and narrative therapy. Specifying that with the particular client group to be investigated, she employs an integrative approach.
The suitability of counselling psychology in working with psychosis *Certain skills are important in working with psychosis* *The complex conceptualization of*	Counselling psychology enables therapeutic work with psychosis: 1) focusing on being present, 2) sustaining the relationship, 3) engaging clients well. A sense of feeling lonely in doing this work? Or a sense of being special? Specialize / specialty. Again – identify herself / skills as special?	P6: Emm, I guess that I don't know many counselling psychologists that specialize in working with psychosis or trained to take that as a speciality so I think that some of the skills that we have are a strength really in working with the group of people I work with because we are able to engage people well. We have a lot of skills of just being present for clients that I think enable you to sustain a relationship when it's very difficult. So I've always felt like that, and yeah but I don't see many counselling psychologists	Not many counselling psychologists from her own experience work with psychosis or get trained or specialize in this field. She perceives counselling psychologists having certain skills, which are considered a strength in working with this group of clients (engaging people well, being

psychosis *Psychosis and alterations in someone's identity and being* *Psychosis and disintegration of meaning*	Key component? Recognition of the phenomenon of 'skill' and 'strength' – these seem to be important concept for her at this point. These skills identified here are some form of strength? Focus on relationships and engagement. Key skills? Key strengths? Interesting to see what others in sample say (if they identify same). Good precursor / orientation to intersubjectivity (relationship and engagement being a component of intersubjectivity) Always felt like this. BUT not many people do what she does. Identification of her skills as different? Special?	do what I do. So I suppose I wanted to support, more of the interest of that in terms of the research as well really. R7: OK. So from your own clinical experience what is your understanding of psychosis, I mean both conceptually and in terms of the clinical presentation of the clients?	present for the client and therefore sustaining the therapeutic relationship when it is difficult). She does not know many counselling psychologists working with this client group and therefore felt that she wanted to support this particular research interest.
Affective and cognitive flow of experience disrupted	There is emphasis on a person's being and identity by focusing both the affective and the cognitive elements Ontological insecurity? Breaking down of stories (narrative)? Implication that stories hold experience together in coherence? Thoughts and identity are also linked through to stories. The 'but' suggests that losing touch with reality is viewed as a separate dimension of psychosis to the storied nature of identity, thoughts and experience (previously mentioned)? On the one hand very relative / social-constructionist (narrative) but the other, contrasted this with the sense that there is a reality to lose touch with (positivism)?	P7: I guess I describe it as a sort of breaking down of stories of experiences in some ways, disintegration of somebody's thoughts, sense of identity but also the being, as someone having lost touch with reality in that process as well. Yes, if that's a simple explanation for such a complex thing. Yeah, I think that's how I see it. R8: You said disintegration. What do you mean by that?	The participant describes the main manifestations of psychosis from her own clinical experiences as disintegration of clients' thoughts and sense of identity, losing touch with reality but also that the stories of clients' experiences are presented by them in a broken down fashion. The participant considers this matter as a complicated one.
	The language here seems confusing and lacks coherence. Wondering whether the invitation to unpack the concept of 'disintegration' might have welcomed a 'demonstration' of what it feels like to work with disintegration. Meaning from past experience. Theory that trauma is important in understanding why this	P8: Emm, an inability to make meaning. From, possibly from, through past experiences, or through, perhaps there has been trauma. Emm, in that a person is unable to sort of confront on an emotional level but also cognitively make sense of those experiences. There is too much for them to cope with, in a sort of, emm, reality based way. And sometimes that meaning becomes more apparent for someone with psychosis.	She defines disintegration as the inability of the client to make meaning of experiences or thoughts possibly because of traumatic experiences. She understands this inability to make meaning as a distinctive feature of this client group. She also understands disintegration as the inability of the client to

	meaning-making goes away. Confront. Experiences? The emotion of the experience seems important to her. Emotions from trauma experiences as linking to cause of psychosis? Emotion affects sense-making? Invoking a stress-vulnerability model? The participant interprets psychosis from the perspective of a person's lived experiences: People with psychosis manifest a difficulty to make sense of their experiences (past (e.g. trauma) and present)	R9: Ok. And what about the sense of identity you have mentioned? What happens there? How do you see that?	confront these experiences and thoughts on an emotional and cognitive level. Clients are engaged in a process of coping with loads of difficulties and are unable to do so in a reality based way.
Psychosis and disrupted sense of self /Ontological insecurity	Again there is emphasis on the alterations of the sense of self and lack of coherence, which makes the work hard. Ontological insecurity? Good prognosis when there is some sense of self from the start of therapy	P9: Emm, I guess there is a very disrupted sense of self. Sense of identity really that people are lacking, a coherent story about themselves, who they are, apart from those experiences. And often is very hard to get to that in working with people. Often is something that, you know its genuinely really working when the client it's on their first interview and you are thinking about what, well when I start to see somebody who are recognizing who they are as a person it probably means that we've gone quite a long way when that really happens. R10: In what way?	There is a disrupted sense of self and these clients are lacking a sense of identity and a coherent story about themselves and they are finding it difficult to differentiate themselves from their experiences. She finds it difficult to engage this client group with their sense of identity and sense of self. When clients are able to engage with their sense of self from the very first session she considers it as a good prognosis for the therapeutic work.
Psychosis manifests differently in different people and its functionality varies *Uncertainty about the origins of psychosis*	Noticing that instead of using the word 'hallucination' or 'delusion' she uses the word 'fantasy', which seems to me carrying les stigma (She is not psychoanalytically trained or oriented). The functionality of psychosis varies across people and less emphasis on aetiology	P10: [p] I suppose is about them being present with themselves and their own potential for growth, to take care of themselves, to be responsible for themselves, and not to sort of being stuck [p] in a sort of psychotic process whether that's about fantasy or denial about experiences however way that psychosis might function for someone. You know, it can function in different ways for people. Perhaps in terms of how it has come about and I don't know if I can always work that out. I am not sure if that answers your question? R11: So you see from what I'm hearing from your own clinical experience psychosis manifesting in different ways in different clients. Is that what you said?	Engaging with their sense of self is understood as being present with themselves, their potential for growth and taking responsibility for themselves. It is also explained as not being stuck in a psychotic process. Psychotic process is defined here as being engaged in a fantasy or the denial of experiences. She is commenting that psychosis takes different forms depending on the individual. She expresses that there is a difficulty in always understanding what has actually caused the psychosis for her clients.
The relativistic approach to the conceptualization of psychosis *Cognitive map of the world affected and disruption of meaning*	Relativistic and subjective approach to the conceptualization of psychosis The participant assumes that she is in a better position to understand the difficulties her clients have been through and how they have affected the way they view the world. Power issues here? She assumes her cognitive map of the world intact!	P11: Yeah. Yeah very much so. I guess I am trying to think through different cases in terms of how I can understand how someone's psychosis has developed like. For some people substance misuse it's a huge element, some people it seems clear that there is a more biological connection, other people there is much clearer link to child trauma and neglect, but it's easy from my perspective often easier than it is for me than for them to understand how it has been difficult for them to sort of developing a cognitive map of the world really and how to make sense of it. [P].	She is taking the direction to think through different cases and how she understands what has caused certain clients to experience psychosis. She mentions substance misuse, biological reasons, childhood trauma and neglect. She specifies that often is easier for her as a clinician to make sense of how psychosis has come about for the client and the

		R12: And are there any other prominent clinical manifestations or symptoms that you have in mind in reference to the clients that you have in mind that are common?	client are finding it difficult to understand what has been difficult for them that might have actually caused the psychosis. They are finding it difficult to make sense of the world since they are lacking the capacity to develop a cognitive map of the world.
Disruption of meaning in psychotic experiences *Meaning making and coherence lacking*	There is an emphasis on meaning making of clients' lived experiences and the function behind psychosis. There is a reason why psychosis has developed for each person	P12: Certainly the way that I see that are not being able to construct meaning out of the psychosis experiences, so explicitly on psychosis but also of their sense of self or past experiences that they may had and not sort of linking back together again. And perhaps in some cases that being quite functional perhaps about not being able to face past trauma and to cope with this sort of affective experience of confronting that, but in other cases it perhaps be more about just a simple break down of the ability to make sense of things that might be more biologically drives rather than psychologically. But I guess there is an inability to construct a coherent story that they stick to that, make sense of and hold on to and move forward in life. R13: Hmm. As you have mentioned you have a more relational way of working with these clients. What does it mean for you to work relationally with this client group?	She differentiates it between the inability to construct meaning out of the experiences of psychosis ad hoc, but also their inability to construct meaning about themselves and their past experiences. In some cases there is a difficulty to sit with past trauma and what that has caused for the client on an affective level, but also to make sense of the biological side of things. The participant finds her clients unable to construct a coherent story about themselves and their life experiences and move forward.
Psychosis related to lived experiences and particularly to breaking of attachments *Acknowledging otherness in psychosis and interventions* *The therapeutic relationship as fundamental and derived learning for clients* *Relational approach enabling clients to sit with and their experiences*	Therapy is tailored-made for psychosis and therefore acknowledging OTHERNESS The 'a different sort of relationship' seems to connote that she compares her own offerings to someone else's which remains unclear. A sense of specialness again? Loneliness in the field/team informing this? The relational approach assists clients to deal with the here and now of the therapeutic process and invites them to deal with their circumstances The value of relatedness in therapeutic work for psychosis	P13: I guess is about attachment experiences, I guess I'm always very mindful that for the most part the clients I work with had difficult childhood experiences, breaking attachments that maybe played out in the relationship that they have with me in some way and that's, emm, also not always able to emm for instance work with someone in a cognitive behavioural therapy way might find my approach threatening, they might be not able to challenge their experiences. I am able to offer them a different type of relationship and I see that as having some value really. Its often not about recovery or change in the same way as I see it with other client groups. Sometime is about being there for the client being able to offer a different sort of relationship that they can learn from. I think sometimes there might be an unrealistic expectation that this might be internalized in that they can sort of move forward from their past difficulties and to develop you know, self care and compassion towards themselves but I see that it helps in a kind of a supportive way which enables them to deal with things in the here and now and to help them deal with some aspects of psychosis rather than to battle with it.	The participant initially introduces the concept of attachment. She expresses that most of the clients she works with had difficult childhood experiences and a breaking of their attachments with significant others and that these dynamics get manifested in their therapeutic relationships. She mentions that it is not always possible to introduce CBT to certain clients as they might find it threatening as this requires them to challenge their past experiences and they resist a lot to that. The participant is able to offer a different approach and relationship for these clients who she sees as valuable and it is not concentrated upon change or recovery as compared with other client groups she works with. It is about being-with the client in a way that they can learn from. She also expresses that often she has the unrealistic expectation that clients might be able to internalize their relationship in a way that it will allow them to move forward in life and

		R14: So how, what does it mean for you to work relationally from the experiential standpoint? Regarding your clinical interventions?	develop the capacity for self-care and compassion towards themselves. Instead she experiences the relationship as supportive and as a medium to deal with features of psychosis in the here and now of their encounters instead of battling with these features.
Psychotherapy as the space for containing the judgement clients' receive from others	Even though she is invited to talk about her own experience she shifts to the 'they' of the clients after a very long pause. Wondering whether she is avoiding here or if she is confused or actually relating to the judgement clients seems to receive from others?	P14: OK. I guess it's about, I suppose relationship. Emm it's probably about me sort of [P]. I think I am very aware about judgment from other people and the level of that effect that they have to cope with and sort of manage that in the room with them. R15: Manage it how, in what ways?	She helps the clients to cope with judgments they receive from people around them and to manage the effect of that in the room with them.
When attachment becomes strong the client is detaching *Acknowledging and allowing closeness and separateness and looking for the meaning behind* *Sitting together with uncertainty in a collaborative manner* *Need for formulation and uncertainty*	Interpersonal difficulties Too much closeness seems threatening for clients Acknowledging the clients' otherness and tend to work differently with other client groups The need for formulation seems to be informed by the difficulties uncertainty brings to the fore	P15: Actually coming back to think about attachments. Sometimes the client has too much and sometimes once we start making some insights and the attachment gets too strong the clients would tend to back off more, avoiding me and me noticing that. With another client group I might be more challenging in terms of working with that, with this client group I might be more aware of it and allow it to happen to some degree by trying to hold something about, about them and what that tells me about formulation and understanding something about their difficulties, their past that often with some people we might be doing some guess work together whether there was some past trauma there or that it might not be disclosed. R16: You have mentioned a couple of times attachment. It seems like it echoes the relational thing for you. The relational way you work. I am wondering whether you can recall any particular examples working with a client that attachment, as you understand it became so much that it didn't allow you to work relationally. P16: Yeah. There are a lot of examples there is it? [p] R17: Well if you try to focus on one so that we can explore that.	The participant mentions the significance of the attachment developed between herself and her clients. She associates a strong attachment with working alliance and insights made together with clients. However, clients at times when the attachment becomes very strong and the get closer they tend to withdraw and she acknowledges that with them. She avoids being very challenging with this client group as compared with other client groups and she allows the withdrawal to a certain degree by trying to make sense of it and in way allowing the withdrawal to inform her understanding of their difficulties but also her clinical formulation about the client. When it comes to work together with the client in trying to make sense and understand their difficulties they are often engaged in guessing together what kind of significant trauma might have been experienced in the past or the client might not want to disclose.
The team's otherness *Separating from the team allows the formation of relationship with client* *Conceptualization of psychosis and negligence in childhood*	Detaching from the team and not identifying with it. (confusion with they/I) She has very quickly formed a relationship with this difficult client as compared to the rest of the team: Feeling special? Identifying with clients? The structure of the team and the way it functions seems to facilitate engagement and	P17: Yes, I can think of a male client that I work with in his thirties. Very long history of psychosis and a lot of risk issues as well being in secure services. Loads of self-harm, command hallucinations that would command him to harm himself and spend most of his life in secure settings. And his engagement with…I work within an assertive outreach team, his engagement with that team it's extremely guarded and they have no, I had very limited information about his experience of command hallucinations so he was very resistant to engage with psychology. But I actually very quickly	She goes on to describe a particular client with whom she works within the assertive outreach team, who has a long history of psychosis, self-harming through command hallucinations and has spent most of his life in secure psychiatric settings. She describes how guarded this client is towards the whole team but that she very

Deep engagement brings disengagement for the client *Structure of the team enabling the work due to flexibility/ allowing engagement and disengagement* *Confirmation of clients' difficulties* *The meaningfulness of resistance* *Non-pathological conceptualization of clients' experiences* *Being-with the clients in their absence* *The space for disengagement allows the client to re-engage*	disengagement in a good way. To conceptualize the totality of the client's experience she is taking into consideration the wider intersubjective context within the team in terms of how the client is engaging and disengaging. Buberian confirmation: she 'confirms' the client's difficulty in relating and separating without challenging it and allowing it to manifest. Again acknowledging their Otherness. She is concerned about clients even in their absence, a deep level of care. She uses the word fantasy again instead of delusions and hallucination. Wondering where this will lead.	formed a relationship with him in terms of thinking about...he was actually experiencing relationship problems at the time, in relation to erm cause of anger difficulties, so I was acknowledging kind of forced control and anger problems so he became guarded about psychotic experiences that might have been quite a fact so he was sort of saying that this is also connected to some problems that I had from long ago that I don't want to talk about. So then actually a huge history of neglect in childhood but he was able to form an attachment and to start to trust me and start working on all of those things. But it felt that it was a huge thing for him to start to open up all of those details so he would...he back off and then he would engage and my team allows the possibility for that, than I am there available. I mean in the team we hold a caseload of 100 clients that would disengage and engage again. So he disengaged and said he didn't want to work anymore but then he wanted to come back in and wanted to reengage with psychology. And it was I guess this was something that we talked not only with me but with the team as well and how he related to the team generally, that he would engage and form relationships and to open up about his experiences and then he pulled back. So it's about sort of noticing that with him but also allow it in a way rather that pushing him and challenging to the degree that he needs to engage, that he has to think of that and that enables him to continue to work with me really. And I suppose I sometimes see working in that context, within that team I am constantly involved in some way, I am still present for some of the clients within my team where I am not necessarily seeing them for weekly therapy sessions or I am still holding them in mind. Enabling them to able to make use of their own defences and to help them reflect on them when the time is right to do that. R18: What kind of defences do you mean? If you are thinking of that particular client? P18: Yeah, emm for that example denial, projection, rationalization, yeah splitting. For others there are all sorts like fantasy, not so much for that client but. Yeah. R19: So let's see all of these because they sound important. So denial, in what way? Denying what? P19: [P] Denial of…probably reality. Erm and I guess denial in relation to past experiences where they have been significant really. R20: What about the fantasy part? What kinds of fantasies emerge?	quickly formed a relationship with him. When they initially formed their therapeutic relationship he was experiencing some relationship difficulties due to anger management issues within his relationship. The participant could engage him with regards to the anger difficulties but he was initially guarded regarding his experiences of psychosis but also past traumatic experiences for which he could link with current difficulties, however refused to disclose. He gradually started opening up which appeared very challenging for him and talked about childhood neglect but trusted her and formed an attachment. But he would engage and disengage which is a common phenomenon with her clients in her team, which was discussed with her team as well. She opened this with the client as well and she describes how allowing him to engage and disengage allowed him to work with her. Even though the participant might not be seeing clients on a weekly session way she expresses that she is available for them and hold them in mind. She allows them to use their own defences and reflecting on them with clients when she thinks that they are ready enough to do so. The clients are denying reality and past experiences that have been significant.
The intersubjective and ontological status of fantasy *The meaningfulness of fantasy as a way of being-in-the-world*	Fantasy (or delusions?) are understood as meaningful and are usually involving relationships with other people or their own sense of self. She seems to be talking again	P20: So I wouldn't say so relevant about that particular case. Certainly for others. Fantasy I see it as providing another way to be, to have a sense of being in the world, to have relationships, and often the fantasy is about relationships really. Or. Identity. And particularly with a very complex client I am involved in working with now who I	She understands fantasy as providing a sense of being in the world for clients. It is often about fantasizing having relationships and certain identities. She can see that many of her clients

Dissociation as a form of disengagement *Differentiation from the team*	about how she is offering something more special for the clients as compared to the team. Looking for meaning appears again as significant here.	see her as having, and with a lot of other clients, having some personality difficulties as well as psychosis and she often, there were times when she was destabilized by environmental stimulus and stress triggers and things and she often behaves as she is a child. She is very dissociative and the rest of the team would see her as playing games, as being a child. So, playing with imaginary friends. R21: During sessions you mean?	are experiencing personality difficulties together psychosis. She thinks of a particular female client she currently works with who she describes as being very dissociative as a result of trying to cope with anxiety provoking environmental factors and as a result she turns to behave as a child and playing with imaginary friends. The rest of the team perceives her as playing games and being controlling.
Differentiation from the team and sense of specialness *The negotiation of separateness and relatedness within the team* *The meaningfulness of lived experience /fantasy*	Working explicitly with delusions and the function behind the absence or presence. Meaning again is fundamental	P21: I am talking about the team generally but she is better able to engage with me. She forms all this formulas, she has the idea that she can create formulas and that God passes these formulas to her for medicines and that will enable her to cure diseases for people and often gets frustrated because it's not possible for her to make this formula for herself to cure her disorder. So that sort of fantasy gives her a purpose, something quite meaningful and important and actually her life has been empty in many ways. She has suffered severe neglect and some degree of abuse although that's not clear, so it's not so clear to work with but loads of attachments difficulties in relationships, family relationships that had broken down, she hasn't been able to maintain a job, so this fantasy is extremely valuable really. R22: OK. This sounds important. I am wondering how do you work relationally with her with regards to the fantasy.	The client generally exhibits this kind of behaviour with other professionals from the treatment team working with her. The participant expresses that she feels that the particular client engages well with her as compared to others. The client believes that God passes on to her certain pharmaceutical formulas to help her create certain medication to cure people from diseases but she gets frustrated as she is unable to cure her own disease. The participant explains how extremely valuable this fantasy is for the client as it provides her with meaning and purpose. The client has suffered possible abuse and neglect and attachment difficulties in her relationships with others and especially with family members. She hasn't been able to maintain a job as well.
Validation of subjective experience *Assisting the client to reflect on their subjective experiences and looking for meaning* *Confirmation of client's experiences*	Validation of client's experiences develops an acknowledgement of her Otherness	P22: Sure. So at times I acknowledge it in sort of noticing, I guess reflecting when is there and when is not there. Sometimes is not there at all and so we are able to have very grounded discussions about problems in her life. Other times is really difficult, but sometimes is easy to reflect upon why it would come about at certain times. Or the fact that is real for her. R23: So when is real for her, because you mentioned earlier about having a grounded conversation when talking about present relationships, so when for example this particular client goes on to talk about relationships that happen in her fantasy how does the relational way you work with her plays out?	She acknowledges and notices the fantasy together with the client but also noticing when the client is not fantasizing. When the client is not fantasizing they are able to have grounded discussions together about difficulties in her life. They are at times able to reflect upon the fantasy and how is it real for her.
In the absence of meaning therapist engages with diagnostic labels *Emotional disconnection brings incomprehensibility of client's experiences*	She earlier said that in the absence of her clients she is still involved and holds them in mind. It is interesting that here the client seems to be engaged in a similar way through her fantasy and she finds it difficult to comprehend. Wondering whether she is negotiating her own separateness	P23: [P] She will often call people silly names. There are times when she would say, oh I have seen you earlier today, and I have already had a conversation with you. I spoke with the invisible you. Or there was a time when she called me the pixie lady for about a year. I guess, I think this is a very difficult case and sometimes it's almost impossible to reflect upon these things. I think there is a fine line for this particular lady between	The participant talks about how the particular client relates to her through her fantasy; that she still fantasizing relating to her in her absence, or giving her new names. The participant expresses this is a very difficult case and that she

Therapist' cognitive abilities affected when emotionally disconnected	from the client. 'In that relationship' seems to demonstrate that the participant is negotiating a distance from the relationship with this particular client? When conceptualization becomes difficult and lacks meaning for her, diagnoses and labels are introduced Meaning appears significant again. Even though she seems to be describing a case where a clients negotiates closeness (i.e. pseudonym given, relating in her absence) the participant understands this as the client's difficulty to connect emotionally. Can we assume her own difficulty here?	personality difficulties and psychosis. And, there are times when there is clear psychosis and other times a borderline personality disorder element in terms of her seeking care. But certainly there is [P] I think there are different ways in which she will be using this fantasy in that relationship and how she understands my role and my own involvement with that. So she might be defending not to get close and also [P] how she sees and makes sense of me. R24: So how are you finding yourself relating to her fantasies? For example you've mentioned earlier that she would tell you she had a conversation with the invisible you, or I can't remember how you actually said it. How are you finding yourself relating to that?	finds it difficult to reflect upon such manifestations. She perceives her difficulties as being informed by psychosis and personality difficulties. Borderline personality disorder features for this client manifest in the ways she's seeking care. She uses the fantasy with her in different ways in which she is trying to make sense of her and her role but also her involvement in their relationship. The fantasy helps her defending in not getting closer to her.
The difficulties of working with delusions that include the therapist *Therapist's detachment brings to the fore doubts about interventions* *Therapist feeling not good enough for the client* *The difficulty of confirming the client's delusions* *Client's delusion including the therapist*	The language used and the tone seems to express that she hasn't been 'heard' for a long time now. She finds it difficult to work with client's delusions when she is involved in them when she is detached. What comes first though? Does she find it difficult that the client is coming to close to her through her delusions and therefore detaches and she experiences loss of meaning? (Searles, symbiosis) Therapist wants to detach and client is engaged with her in her absence	P24: Erm I think it's been very difficult actually. It's being quite a long time now. Initially I would feel quite uncomfortable with that I think. And I'd find it much more difficult to be present and I would be probably more keen to reflect on my need to pull back from the work and [p] I would be questioning whether there is any value of me being there. I mean whether my presence increases distress rather than help and I'll be struggling with my confidence regarding the interventions. At times I think I've been more able to stick with it and acknowledge actually that this person sort of needs this fantasy and it's not necessarily my job to have to deny it. R25: So you are saying that at times when she talks about the fantasy you're questioning your presence, you are questioning your interventions and you wonder whether you're helpful towards her.	The participant recognizes that she is finding it difficult to relate for quite a while now. When the client is talking about relating with her in her absence (i.e. the fantasy) she initially finds it comfortable. She then finds it difficult to be present with the client and she's pulling back from the relationship to question her need to back off and questions the value of her presence. She doubts her own interventions and lucking confidence while she wonders whether her presence increases anxiety in the client and being unhelpful. At other times she will acknowledge the client's need to hold on to the fantasy and realizes that she doesn't have to deny the client's fantasy.
Doubting the therapeutic work when she is frustrated and detached	A need to avoid the client? What is this frustration really about?	P25: Yes. So I'll be wondering whether I should be working with this person. Or would it be a better place somewhere else. I'll be frustrated with her perhaps. R26: Frustrated with her? Tell me more.	The participant is wondering whether she should be working with this client at all and if it would be a better idea if the client was seeing someone else. She feels frustrated towards her.

	There is a very long silence here and she seems getting in touch with her feelings	P26: [P]	A very long silence.
		R27: What is frustrating?	
Separateness brings frustration and incomprehensibility Technical language used when therapist is detached *Formulation is not enough to make sense of client's experiences* *Client's incoherent sense of self frustrates therapist*	The difficulty of the therapist to relate is not informed by the client's difficulties here but is understood as the therapist own difficulty. The technical word 'formulation' is used in presence of detachment She talks about wanting the client to have a coherent sense of self and later on she will talk about her own dissociative processes. Does she talk about her own ontological insecurities?	P27: Not being able to relate [p]. And not being able to make sense of her really. I mean, I have a formulation, but there is too much there to make sense of. There is too much discontinuity and it's impossible to put the links back again and that she has a coherent sense of self or how I would like her to have.	She is not able to relate and make sense of her client and she gets frustrated. She has a clinical formulation about the client which doesn't seem enough for her to make sense of the client. She talks about the discontinuity in their work and she finds it difficult to connect all the links together. She also talks about the lack of a coherent self and her own need to experience her as coherent.
		R28: Ok. So when you are finding yourself getting frustrated, how does your frustration or any other difficult feelings you have, affect the therapeutic relationship if at all?	
Separateness from the client causes dissociation and collapse of meaning *Therapist's autonomy threatened* *Cognitive and affective alterations* *Collapse of meaning appears threatening for the therapist* *Separateness is related to dissociation and lack of meaning* *Embodied attunement with client /disembodiment* *Therapist's ambiguous pre-reflective structure manifested through dissociation*	She understands dissociation as an outcome of not being able to make sense. Is detachment preceding the absence of meaning? The space between collapses and therapist's autonomy might be threatened. The inability to make sense is experience as caused by something external, outside of the therapist? Can we say that it's an experience of self-alterity? In other words that the therapist is experiencing self as Other? Therapist dissociates and the client seems to embody that with her fantasy of talking to the invisible her Buberian 'leaping into': The unpredictability of a genuine dialogue with one's whole being as well as one's vulnerability: Therapist feels transformed Laing's concept of 'engulfment' comes to mind: Therapist autonomy is threatened The dynamics of separateness and relatedness in the space between brings to the fore therapist's ambiguous pre-reflective structuring of meaning (i.e. dissociation) Moments of disembodiment for the therapist in the disruption of the fluidity of affective experience and her directedness towards the client.	P28: Erm [P]. I think it makes me back off a bit. Probably, erm even to a degree, it might sound extreme but sort of dissociate a little bit. I guess I see myself from as her. Finding it very difficult to make sense of what I am sort of seeing. I guess I feel something's thrown at me.	The participant backs off in these cases and dissociates to a degree. She identifies with the client and she is finding it difficult to make sense of what she sees in the client and feels that something's thrown at her.

		R29: And you say you're dissociating.	
Therapist attuned to client's detachment and loss of meaning	Therapist is losing connection with the client. There is a sense of attunement to client's affective state Disruption in the flow of cognitive and affective experience	P29: Well that's an extreme term isn't it? I'm not that present with her. Because that's too much. And that's what exactly is for her. But I think it's very difficult to find the space to make sense of that. R30: OK. So in that situation, in that process of trying to make sense and becoming frustrated what else happens in the process to reach the narrative, to reach the client?	She understands it as not being present with the client because she is finding it too much and that's how it is for the client. She is finding it difficult to make sense of that though.
		P30: In terms of the relationship process on its own or in terms of my interventions? R31: I think both sounds important.	Relationship process or both she wonders.
The significance of supervision *Interventions informed by the dynamics within the relationship* *Careful consideration of closeness and distance* *Therapist's difficulty in sitting with the client in uncertainty magnified by settings' over-engagement with results* *Therapist and client need some space from the therapeutic relationship* *Setting as disabling and discouraging*	The therapist suggests that both client and herself need to reduce the quantity of sessions. But is this more of the therapist difficulty to stay in the space between? The way the therapist describes that the setting/team seems to be implicitly 'intrude' her way of practicing appears similar with the way she experiences the client intruding her by feeling that something is thrown at her. The way the NHS's agenda is internalized and its outcome-focused strategies seem incompatible with therapist's approach and mode of relating to clients	P31: Well sometimes there is a natural disengagement. At times there's been an admission to the hospital. [p]. I think I've been aware for this person that I have been discussing in supervision recently that erm we have constructed a plan together that we will reduce the frequency of our sessions and I found myself reflecting back if it was the right thing to do really or if I was getting pulled in sort of abandoning her in some way, or rejecting her or avoiding her. Because you see, what was difficult for me was needing to have an intervention really needing to do something in our meeting so that it would be valuable for the NHS. So working with evidence in a way, and having confidence about that. So there is a need to force something, to do, do to her, to feel that therapy is more constructive. And doing the sense making when she is allowing the sense making really. R32: You have mentioned a couple of times the disengagement from your side. And I'm wondering how you handle the emotions of disengagement when you are with the client. P32: Are you talking about the disengagement in the room? R33: Yes, in the room with the client.	There is a natural disengagement from the client's part, which might lead to a hospital admission. In thinking about the particular client she talks about how they have decided together to reduce the frequency of their sessions and she wonders whether the disengagement might has been mutual as she considers the possibility that she got pulled into abandoning, rejecting and avoiding her. She talks about her need to employ measurable and evidence based interventions so that they can be valuable for the NHS and allowing her to feel confident in a way.
Emotional disengagement difficult and on embodied level exhausting for the therapist *Setting makes*	She is invited to talk about how she personally deals with her own emotions of disengagement from the client and she talks about how she perceives her role within her team/NHS which confuses her. The psychotic processes of the	P33: Well it's difficult really. I mean for the most part, I tend to think of my role in the NHS really and it can just be totally confusing. Exhausting. I recently receive more of psychodynamic supervision because I have been supervised for a long time from a CBT perspective and not from long-term psychotherapy approach supervision but that's their main approach and I've realised	She is finding it difficult to handle the disengagement feelings. When she disengages she tends to think of her role within the NHS and she can get very confused and exhausted in that process. She recognizes

relational and reflexive work difficult *Therapist disengaging from the team* *Setting as disabling*	team?	that this didn't allow me to reflect on this and other things [P].	the benefit of receiving psychodynamic supervision lately as compared to CBT which didn't allow her to reflect on this matter and other material.
		R34: So what other kind of emotions emerge for you when you are disengaged from the client?	
Disengagement is experienced on an embodied level as boredom, frustration, confusion and anxiety		P34: Boredom sometimes, frustration, confusion, anxiety. I think that's the main menu really.	Boredom, frustration, confusion, anxiety.
		R35: What is the anxiety about?	
Disengagement brings uncertainty	The language she uses here (manageable, unhelpful, responsible) seems to echo what the settings has 'thrown' at her which seems to intrude into the work with the client and sabotaging the therapeutic work	P35: So, where is this going? And to control it in some way to keep this person safe and whether that's possible. Whether we can sort of, I guess something about things being manageable and not putting things in the way that might be unhelpful. I am feeling quite responsible for that really.	Uncertain about the future of therapy and the safety of the client. Feeling responsible for the client and having the need to create the appropriate settings to make things manageable and not being unhelpful for the client.
		R36: Unhelpful for whom?	
		P36: Unhelpful for the client.	
		R37: Can you think of an example? That sounds very interesting. What can be unhelpful for the client?	
The meaning and function behind fantasy/delusions *Therapist acknowledging clients' difficult circumstances* *The importance of meaning and its disintegration due to difficult experiences*		P37: I guess it's coming back to the fantasy stuff for me actually. Look at it from a more reality based way trying to think about how it functions facing it, the reality of this is a person that hasn't been able to sustain a relationship, and desperate to have children, and substance misuse, and seems unlikely to achieve those things. And there is a huge you know, erm human beings, the majority take this for granted really. Not easy to accept. And by actually being the person that finds the smallest thing difficult to cope with and I guess there is a very fine balance to be able to sort of see these kinds of things and be able to see some meaning and make sense of it, but that too much leading to all sorts of disintegration really.	She finds herself being unhelpful when she is trying to make sense of clients' fantasy from a reality based way. However the reality of many of her clients is that they have difficulties in sustaining a relationship, they are desperate to have children and it becomes difficult for them while they find it difficult to accept the difficulty. She acknowledges that the average person takes the above for granted while for her clients who are vulnerable in coping with minor difficulties it becomes difficult to make meaning out of their difficulties and make sense of them which leads to different kinds of disintegration.
		R38: And talking about meaning how are you finding yourself making meaning or not of their inability to engage pragmatically and on realistic grounds?	
Adopting a second-person perspective	The therapist seems to be engaging a second person perspective in her approach with	P38: It would come up in the process. Noticing patterns, the here and now statements and what happens between us. So for example I've noticed	She notices herself trying to make meaning through the therapeutic process by

Therapeutic process involving the moment to moment affective changes	the clients.	that we get pulled in a fantasy, the formulas again. You are sharing with me all those formulas but I'm wondering whether we can reflect on them instead of how they have come about and sometimes we are moving towards me been drown into being in this fantasy, being given a formula and being asked if I can take it on and being able to say 'what just happened there, the dynamics have changed' and then we are talking about something that happened yesterday. R39: So you are mentioning some challenging issues that are brought up in the sessions. I'm wondering and thinking towards the other spectrum in thinking about the particular client or other clients that you've talked about, moments where you've felt connectivity and proximity with them. If you can describe these moment, how they happen, when they happen, if the happen?	noticing the clients' statements in the here and now of the session. The participant provides an example with a particular client discussed above who engages in a fantasy of formulas with whom she acknowledges when they are both getting pulled in her fantasy. She encourages the client to reflect on the content of the fantasy instead of how it has come about. The client invites her to get involved in her fantasy and the participant responds by acknowledging how the dynamics are shifting by asking her to get involved and they end up talking about something irrelevant.
Feeling being special for clients *Technical interventions not allowing connectivity to form/I-Thou vs I-It* *Being-with challenging*	Offering a human relationship which is focused on being-with rather than technical interventions Therapist is present in the betweenness as a fellow human being in the service of the Other (Buber)	P39: You mean moments where I felt more connected with them? Erm [P]. You know thinking about it I have a great influence over, but often is also erm [p] sometimes with humour, or sometimes it can actually come out of the discussions with them, it comes out of the more human relationship, rather than me trying to employ a diary for them if I am using a CBT intervention. And I guess that brings me back to the difference between being and doing and being aware of that. And being-with allows forming the relationship but with this client group that comes with its challenges because often many difficulties arise in the relationship. R40: And how would you describe yourself in a being-with mode with a client?	She feels that she has a great influence over her clients. Connection manifest itself through humour, through their discussions in a more human relationship way when she is not engaged in her need to employ certain CBT interventions like diary keeping. She introduces the being versus doing and when she's in a mode of being-with the client this allows the formation of their relationship which also comes with its challenges.
Being-with allows connection with therapist's sense of self *Being-with allows the use of self in the process*	Being-with the client allows a more holistic conceptualization and helps avoiding compartmentalizing the person. Acknowledging and experiencing the other's wholeness allows the use of self in the process while the therapist remains connected with her own self Being-with allows the therapist to connect with herself	P40: [p] I guess I am more present emotionally in terms of acknowledging the whole person, not just the psychosis so we might not be talking about that. With that I am more present within myself, I bring more of myself to that. R41: So you are more in touch with yourself. P41: Yeah. Yeah. Much more. R42: And how would you describe the relationship between you and the client when you are in that state of being-with with them? How would you describe it?	She is emotionally present for herself and the client and she brings more of herself into the relationship. She finds herself acknowledging the whole person in the client and not just the psychosis.

The importance of meaning *The meaningfulness of the relationship* *Relationships as the source of meaning* *Meaning co-constructed and inherent in being-with* *Being-with and the confirmation of the client and therapist*	In the state of being-with the therapeutic relationship is experienced more real and there is less battle for meaning as the relationship itself is the source of meaning Being-with allows the therapist to acknowledge clients' otherness and provides the space for them to attach the meaning they want to their experiences and fantasies. Being-with allows the therapist to be fully present	P42: Much more real. Less of a battle. I guess there is less of a battle for meaning really. I suppose is the difference there between trying to sort of either dissect or change meaning from a sort of CBT perspective. Working with beliefs or questioning delusions or whatever might be. To just being-with, hearing how they make sense, how the client makes sense of things. But often I think if someone's not ready to question or to change meaning they would have got it out in the first place. But again if they might be questioning meaning then this brings us more back to the relationship. So being present there and observing it. And this allows them to be present, I see that they feel not judged and more accepted and feel warmth in the relationship. Humanistic staff. R43: How are you experiencing the warmth you are talking about? What is it like for you?	She is experiencing the relationship as more real and she doesn't battle with the client for meaning making. She is not trying to employ CBT interventions to question beliefs or delusions or anything else that might manifest and sticking to how the client makes sense of them. She's being present with the client in a being-with mode and allows them to be, and she observes everything that happens rather than challenging it. This allows the client to feel the warmth in their relationship without feeling being judged. However, if the client takes the initiative to question meaning this brings things back to the relationship.
Existential acceptance of client's and therapist's facticity *Self-affection and hetero-affection*	An existential acceptance of client's and therapist's difficult life circumstances. Being-with and being attuned to clients allows the therapist to come to grips with her own difficulties in life. Therapist is affected by herself and affects herself through being affected by the client who is affected by herself.	P43: [P] I guess it comes up with just the acceptance of things. Much more existential level really. You know really difficult things happen in life and I suppose with that probably my awareness that difficult things happen in my life as well and how do I deal with that. And about being more grounded in that and I think the warmth is also from the position of the awareness of myself and from my own experiences of [P] if that makes sense really. R44: And how do you feel talking about it now?	It is about accepting things as they are in an existential level. She acknowledges that it is a fact that difficult things happen in life and she becomes aware of the difficult things that happened in her life and how she deals with it and she becomes more grounded. The warmth also comes from the awareness of herself in sessions.
	It reminds me Buber who suggests that the space between is a risky one because it involves change for both participants	P44: It's interesting. Emm, but I guess it feels risky in the work. R45: Risky in what way?	She finds her own reflections interesting but she finds it as a risky process in her work.
Sitting with facticity and limitations *A great sense of responsibility for the client* *Being-with rather than doing* *Therapist belief system challenged* *Being-with and attuned to one's own madness* *Relational work confronting therapist's ontology*	Therapist involvement in the space between generates the sense of risk. (therefore the possibility for change). She feels decentred. Both client and therapist are being affected through a dynamic process which is not encapsulated within them but between them. The therapist is more interested in providing a relational basis and being available to the client instead of focusing on particular interventions. Closely attuned to the client the therapist is in touch with her own madness Relational work with psychosis	P45: [P] I guess those things cannot necessarily be fixed, acknowledging that. Erm... that actually you're to meet somebody's life in a very significant way that it's quite a big responsibility really. Especially when you might not be able to do much about it. Erm, other than to be there in some cases I think. Not all. I guess it's an entering into a certain amount of madness really. And that's often a challenge depending on all sorts of settings that you're working in, but you often go back to an environment that it hasn't got much of a capacity to see life on a continuum and acknowledge our own madness. I think being with someone often means acceptance of some of those beliefs you know…people have beliefs that are unusual and unproven and superstitions and myths that they hold on to and they are not pulled in these. And in the rest of my working life I am not religious as a person necessarily, or these huge amounts of customs and actually as a	She talks about the responsibility she feels towards her clients. That for her is about meeting a client's life in a very significant way, even in the cases when she cannot do much about their difficulties. There is a challenge of entering a certain amount of madness when working with this client group which also depends on the settings of the work. Her experience of the settings she works for is that they haven't got the capacity to see life on a continuum and acknowledge the madness of human beings in general. When

Relational work allows confirmation of otherness	allows the therapist the opportunity to acknowledge Otherness meaningfully but it confronts therapist's ontology The therapist 'confirms' the clients' phenomenological world without judgment while she still acknowledges her own being (reflexive awareness of her own worldviews) Buber's concept of 'inclusion' comes to mind: the therapist visits the standpoints of her clients and therefore acknowledges their otherness without giving up her own beliefs and points of view.	person I sort of resist to that but in my client work I accept it and see that it has value for people but it forces me really to question my own beliefs. If I'm truly present with someone it challenges me. R46: So, when you are in the mode of being-with the client and you feel the warmth you were describing earlier it seems that you are not only engaged with the other, with the client, but you are also engaged with yourself. P46: Yeah. R47: You also mentioned earlier about the settings, how the setting affects the way you work. I am wondering how you think the settings affect your work with this client group.	being-with someone it means accepting their beliefs to a degree; beliefs that might be unusual and unproven, or superstitions they might hold. She acknowledges that as a person she is not very religious and she finds herself resisting to many cultural customs and superstitions but she recognizes that she accepts them in her clients. She can make sense of them and recognizes their value. If she is truly present with clients she feels challenges by their belief systems as they challenge her own ones.
Meaning making for team dynamics and therapy process *Setting as disabling by judging the clients* *Mismatch between therapist's and team's expectations of therapeutic work* *Setting as disabling my sabotaging the space between*	The complexity of meaning-making process on the micro-level of the therapy process and the macro-level of team dynamics	P47: I mean there are loads and loads of ways. But I guess the main thing that came to my mind really was being in a team where I am the only psychologist. And, they are quickly not valuing the difference in beliefs and form a certain attitude about a client. So I'll be quickly faced with a lot of judgements and appraisals about…someone being controlling, playing games, a lot, and a huge level of anxiety and chaos around whether this person has a psychosis or not. There are times when it is clear that there is psychosis but other times there appears to me that something else is happening. And a certain expectation about what a team should be able to achieve. And how things are making sense. I think I take this as part of my job really. How they are making sense of that and sort of being able to make sense about the team dynamics as well. But sometimes coming to a busy day to see a client that is that complex you are already not really present to yourself. And that has a direct influence on the work really. You can find yourself being pulled into other people's attitudes and ideas about what's happening. The third person being in the room in a way, the psychiatrist, the nurse, the social worker etc. R48: And that has the potential to affect the therapeutic relationship. Are there any other ways that the therapeutic relationship can be	The participant is the only psychologist working in her team and there is a different way in which she and the rest of the team values difference in belief systems in clients but also they hold certain attitudes about this client group, which differs from her own. Other colleagues become judgemental about these clients, perceiving them as controlling or playing games with staff. There is also a great anxiety manifesting within the team with regards to a valid diagnosis of psychosis and quite often she it is not very clear about the diagnosis while she perceives clients manifesting comorbidity. Even though there is a certain expectation about what a team should be able to achieve and how the team is making sense of clients' issues she finds herself making sense of them in a different way. She considers that part of her job is to make sense of how the rest of the team is making sense but also the team dynamics. Part of the difficulty is that she feels getting pulled in the team's attitudes and ideas about clients, which has a direct influence on her work.

Setting as disabling by not being sensitive to therapeutic boundaries		affected by these external influences? P48: I mean the boundaries issues are big, especially in my team as compared to a CMHT setting or an individual therapy setting where you can manage that. You know to a degree. For example if a client of mine contacts the service, the person that answers the phone might respond in a different way that I would. Recently for example I had a client who contacted the team and mentioned that they had a physical health problem on their grown and the admin staff said why don't you show [redacted] when you see her. And that's how the session started. So different contacts with different people introduce very different boundaries. There is a constant renegotiation about all of that. R49: And you also mentioned earlier something about the NHS expectations which is more to the side of doing things and be productive. And you described earlier how that affects your own expectations and how you relate to the client. And that sounded important for you. Can you say more about that?	These ideas and attitudes are present in the room with her clients and they are represented as a 'third person' in the room, being the psychiatric, the nurse, the social worker etc. She introduces the importance of boundaries and from her description it seems that they are often lacking. She compares her team with a CMHT team or a private practise setting where boundaries are more manageable. She provides an example of clients contacting the service to arrange a session instead of contacting her directly and that the person answering the phone might respond differently than she would have responded. She also gives an example of a client showing her their grown because of a physical condition they had who was encouraged by the admin staff. She finds herself constantly renegotiation boundaries with the rest of the team.
Team disabling relational work by over-emphasizing doing than being *The gaze of the team penetrates the space between* *Team reticulates the relational approach* *Setting as disabling with financial pressures and outcome-focused agenda*	The gaze of the team seems to penetrate the space between client and therapist. (wider intersubjective considerations)	P49: Oh yeah. Yeah. Well I am at a setting where is primarily nurse laid; psychiatric nurses and they have a certain attitude, which is very pragmatic. Focused upon you know, skills, solutions, fixing things, and that's very strong. Often there is a sort of gaze on you, what are you doing, what are you contributing to working with this client or there is a perception that If I was to talk about being with somebody I get laughed at the team at times. And it's quite hard to fight for that. I think alongside pressures, lack of recourses and pushing towards certain pathways and the pressure when there is no improvement from these clients that we might get paid less if we continue to work with them. You know, that is our job to move their mind and if not they will start not paying us or having less resources for these people that are really complex and in some cases you can't expect to get huge results. R50: So it seems that the gaze of the settings is limiting your work and it's pressurizing you. P50: Yeah. Yeah. R51: I was thinking of asking you, given the relational emphasis of the therapeutic work that you talked about, how you use, if at all, the space-in-between you and the client?	Psychiatric nurses who have a strong and pragmatic attitude by focusing on skills, solutions and fixing things surround her. She experiences their gaze as having an assessment and critical role with regards to her contribution in working with this client group. She doesn't feel comfortable talking to the team about being-with clients as she expects that they will laugh at her. Within these pressures, with the lack of resources and with clients not showing improvements there is a pressure that she might get paid less when she is not working in a specific way with them. It is expected that clients must show improvement and she doesn't like working in that way especially with this client group which is complex and you cant expect huge results.
Therapist engaging and disengaging in		P51: In the room [P] I suppose different levels of	She mentions the use of

the space between *Detaching from client generates reality based interventions*		silence. I guess it makes me think about that kind of attaching and moving away to a degree. I think there is a way in which I support that in terms of how I ground people and at the end of sessions and focusing on something that is reality based and more real. But I am detaching a bit in that, in sort of ending the encounter. R52: Sorry, so you feel that you are detaching yourself by trying to ground in the here and now?	different levels of silence. Silence allows her to reflect upon attaching and detaching from the client. She finds herself detaching in the way she ends the encounter by focusing on reality-based matters.
Emotional disengagement generates superficial engagement *Superficial engagement serves as a containing agency*	Idle talk, Heidegger I-It, Buber	P52: I suppose my thought was about ending the session and that person is not necessarily going to have that sort of relational depth with me. There is something about ending it and moving into some more superficial topics really and that thing about having that person sort of getting some of their defences back and to be grounded but not exposed. R53: Exposed?	Ending a session with a client that is not able to come to a relational depth with its done by her opening up more superficial issues to the encounter which allows them to get their defences back in a kind of a grounded but not exposed way.
Being-with makes the therapist feeling emotionally transparent and exposed	Being connected to personal difficult feelings, feels likes she is exposed to the client. Therapist affective state is not hidden	P53: I suppose what I mean by that is being in touch with some of the difficult feelings that might been felt in one session and about trying to contain that. R54: You mean difficult feelings for you or the client? Or both? P54: Both. Yeah. R55: And where do you think, if at all, difficult feelings of yours and the client's meet? Do they meet? P55: Yes, occasionally. R56: Describe me this meeting.	The participant by detaching at the end of the session allows the client to contain difficult feelings that have been felt during the session and this allows a kind of containment of these feelings.
Intersubjective nature of client's delusions with reference to the therapist *Acknowledging the limitations of the therapeutic work and finiteness*		P56: I guess there are moments of reflection and challenge and quite recently I had a quite significant reflection with somebody about them acknowledging how they had a fantasy that I could look after him. And that was sort of a replacement for someone they worked in the past with whom they had a good relationship with and then he experienced the loss, and then that I am not always going to be here and I can't actually do that. That as much as other people have let you down and rejected you I will too. And to be able to sort of sit with that. R57: And thinking about how you are impacted on any kind of level while working with this clients, I'm wondering how during sessions and if you are impacted on a physical level, on an	She talks about moments of mutual reflection, which can be quite challenging and she provides a particular example. This client had a fantasy that she could look after him, which she understood as an outcome of a traumatic past experience with a previous therapist with who the client had a good relationship with which ended with disappointment. The client according to her tried to replace the previous therapist with her but she had to work with that in help him to deal with the fact that she can't always be there for him and she will let him down and reject him as other people have done in the past.

		embodied level.	
		P57: I guess to a certain degree you know, in thinking about feeling anxious at times or feeling that embodied aspect to that, or feeling lethargic and exhausted, tired.	There is a physical element when getting anxious or feeling lethargic, exhausted or tired.
		R58: And how does it feel in your body if you can recall, on moments like the previous ones you described earlier when you disengage and you feel quite frustrated. How does it feel in your body?	
Embodied disengagement	Issues on embodiment when the therapist is disengaged from the client Again something external seems to be related	P58: Tensed. A feeling of something knocking on my head, restlessness, agitated.	She feels tensed a pressure on her forehead, restlessness, agitated.
		R59: And what happens after a session finishes? Is there anything particular that you feel or is there any particular way you are impacted? How does it feel?	
Setting as disabling *Meaning is paramount after the session*	The setting is again experienced as not providing any kind of containment especially after difficult sessions and not being a space which supports a reflexive stance	P59: [P] I guess it all feels like leaving one world and going back to another one. Another one which is actually the setting in which not everybody can understand. Sort of having to re-orientate yourself. And often to make some space for yourself. Particularly with clients that appear disrupted in terms of their thoughts, sometimes it's quite difficult to just go from the one to the next. You need a little bit of time to make sense of all that.	She describes a transition from one world to another in which there is not always much understanding and a kind of reorientation is required while making some space for herself. In cases where she works with challenging clients with disrupted thoughts she needs some time before moving to the next client to allow herself to make sense of the session, the client.
		R60: So you are describing a transition from one world to the other, from the session that ended towards the setting, which sounds like a challenging transition.	
Being vs. Doing *More connected with clients rather than the rest of the team*		P60: I guess it's about moving from being to doing.	Moving from a being-with mode to a doing mode.
		R61: OK. We are approaching the end. Is there anything you would like to add which is of personal importance to you when you are working with this client group? Any insights?	
Therapeutic pluralism *Using specific interventions to facilitate detachment* *Detachment comes naturally and allows the client some space to reflect*	Pluralistic work Is she saying in other words that she is disengaging to protect herself? To protect herself from what? From the space between? Is it becoming too much?	P61: I think what was interesting as I was reflecting on, was probably the different modalities that I might use. And making sense of that from the relational or the psychodynamic approach and I think sometimes when I start looking for tools and they might inevitably be CBT related tools, because CBT has a lot of tools, more of the doing interventions I wonder if that relates to a, I guess it's another way for me to sort of structure myself and make sense of what's happening but also possibly sometimes another detachment from the being-with. And I guess that's quite interesting if we are reflecting on it in that way. Often it seems very natural and perhaps it's a useful thing to do and bring some of that to my work. But I think it's also helpful to	She finds it interesting that she was reflecting throughout the interview about the different modalities she applies to her work. She shares an insight (informed by a relational and psychodynamic perspective) about her need to employ CBT interventions. Her need to employ these tools and being in a doing mode is understood as a way of making sense of what's

		reflect on it really. R62: So while you were describing it, I had a picture in my mind, you the client and the tools. So you mentioned before that your engagement with the tools might be expressing your disengagement with the client. Is that what you said? P62: Yeah. [P] R63: OK. What purposes do the tools serve for you?	happening for the client but also avoiding the being-with. It often feels very natural for her to engage in that way and she can see the benefits of it, however she considers it important to reflect upon.
'Technical' interventions introduced by therapist vulnerability *Therapist's defences allow her to be present* *Technical language employed when reflecting on disengagement*	The tools serve as a mean through which she manages her own anxieties related to the therapeutic work Technical language is introduced again when she is reflecting about disengagement Formulation against the uncertainly of client's circumstances	P63: They also help me to keep being there. And I was thinking it in with regards to their own defences. They need their defences and I need mine. And sometimes this enable me to, helps me to understand something to make sense of what my role is, in being in the room with them. And it allows me to think of formulation when it comes to this client group because I don't think I could confidently say that my clients that present with a sort of residual psychosis that I have a formulation about and understanding that I am 100% right. I think sometimes these tools, these formulations help me to be able to make sense of the case and to take some meaning from it all. And to sort of be there and have some kind of relationship. R64: So it's a matter of professional confidence and at the same time managing your own anxiety in dealing with the disengagement from the client as well. P64: Yes. R65: Anything else that comes up? Anything prominent in you at the moment? P65: No, I don't think so. R66: Thank you very much Paula for taking part in this. Well let me switch off the recorder so that we can debrief. P66: OK. Thank you	CBT tools help her to ground herself in the room with the client; they keep her there. It is also viewed as a way of defending. She expresses that clients have their own defences and she needs to have her own ones. CBT allows her to construct a formulation about the client, which is of great importance for this client group as she cannot be fully confident about formulation. She adds that formulation allows her to make sense of the client in a meaningful way and it allows her an opportunity to form a relationship.

Appendix X: Themes and subthemes with excerpts for entire sample

MAJOR THEME 1: THE PRIMACY OF SENSE-MAKING	
SUBTHEME 1.1: FOCUSING ON MEANINGFULNESS AND COMPREHENSIBILITY	
1. PAULA	*"Emm, an inability to make meaning. From, possibly from, through past experiences, or through, perhaps there has been trauma. Emm, in that a person is unable to sort of confront on an emotional level but also cognitively make sense of those experiences. There is too much for them to cope with, in a sort of, emm, reality based way. And sometimes that meaning becomes more apparent for someone with psychosis"* ***(P8/L26-28)*** *"…in a sort of psychotic process whether that's about fantasy or denial about experiences however way that psychosis might function for someone. You know, it can function in different ways for people"* ***(P10, L36-37)*** *"…but it's easy from my perspective often easier than it is for me than for them to understand how it has been difficult for them to sort of developing a cognitive map of the world really and how to make sense of it"* ***(P11/L43-44)*** *"Certainly the way that I see that are not being able to construct meaning out of the psychosis experiences, so explicitly on psychosis but also of their sense of self or past experiences that they may had and not sort of linking back together again"* ***(P12/L47-48)*** ***"****Other times is really difficult, but sometimes is easy to reflect upon why it would come about at certain times. Or the fact that is real for her"* ***(P13/L114-115)*** *"Fantasy I see it as providing another way to be, to have a sense of being in the world, to have relationships, and often the fantasy is about relationships really"* ***(P20/L100-101)*** "*So that sort of fantasy gives her a purpose, something quite meaningful and important and actually her life has been empty in many ways. She has suffered severe neglect and some degree of abuse although that's not clear, so it's not so clear to work with but loads of attachments difficulties in relationships, family relationships that had broken down, she hasn't been able to maintain a job, so this fantasy is extremely valuable really"* ***(P21/L108-111)*** *"At times I think I've been more able to stick with it and acknowledge actually that this person sort of needs this fantasy and it's not necessarily my job to have to deny it"* ***(P24/L129-130)*** *"I guess it's coming back to the fantasy stuff for me actually. Look at it from a more reality based way trying to think about how it functions facing it, the reality of this is a person that hasn't been able to sustain a relationship, and desperate to have children, and substance misuse, and seems unlikely to achieve those things"* ***(P37/L172-174)*** *"Much more real. Less of a battle. I guess there is less of a battle for meaning really. I suppose is the difference there between trying to sort of either dissect or change meaning from a sort of CBT perspective. Working with beliefs or questioning delusions or whatever might be. To just being-with, hearing how they make sense, how the client makes sense of things"* ***(P42/L197-199)***
2. BARBARA	*"So it's like too much pressure and then something erupted and that the psychosis is meaningful. It's quite of come to a...emm...you can see once you get to know them and you can see the meaning of psychosis, it's not separate of who they are. Not in terms of separate of who they are that they are paranoid or...but in terms of saying a lot about some aspects of their internal world and emm...deficits that they have and what part of this has caused the break"* ***(P16/L55-57)***

	"Yeah. Also it has a function for them but it also has a story. It tells their story. Emm...we had like one of my clients would say that one that during his first psychotic episode he thought that there was a big secret he knew and can't tell anyone now. He knows it and the family knows it but he can't tell because there is always someone listening. So everybody knows about it and nobody speaks about it. Now, at the moment we have family therapy with them and this is almost an accurate description of what's happening in the family. There is something that everybody knows about, nobody speaks about it. So it tells a story. Also there is a function because he needs to organize his world" ***(P17/L61-65)***
3. BETH	*"So very much with, Ok, people who come up with, who have a diagnosis of psychosis, often manifest difficulties at particular time, and that time most likely is dramatic, but I can't know for sure because the history was very blurred, missed their histories…emm…we did have some people with very, very, very, active psychosis and it was very interesting to see that actually some of the stuff they were saying, I mean I can't know if they were true, but I believe that they are, but although it was very, very difficult to understand and it was, emm…it seems like the…basically there was meaning behind the voices and the delusions and that sort of thing"* ***(P9/L53-57)***
4. CARLA	*"But when you are thinking in another way, psychodynamically, psychosis might be a situation, where yes you do have some of these symptoms, but not necessarily have the whole picture but more importantly these symptoms are meaningful. So I would say that somebody it's quite psychotic when his relationship with the world has changed, you know, also the internal and external. So, ok, there are delusions and hallucinations but they are not organic, well, usually, if there are no drugs etc, but they have a deep and meaningful psychological value"* ***(P2/L9-L13)*** *"And then, he, he started feeling that I was, telling me that I was a witch that was doing spells on him. But see everything was meaningful. You know, even though his story sounded crazy, the feelings behind his psychosis were so real. Very real actually. Yes, the feelings were authentic, and I could relate to that"* ***(P14/L90-92)*** *"So as I said earlier, there was, often you act when working with psychosis you act immediately and it's only afterwards that you get to understand more fully what has happened and it's always, well almost always meaningful. I mean the patients' behaviour; paranoia, delusions etc are always meaningful. So in this case, when this patient took the pen container, and he was really, he was ready to through it, he was, at least it felt to me that he wanted to receive something from me by force"* ***(P31/L238-241)*** *"All the paranoia, the hallucinations in the room, was he, he was creating another persona in the room, one that he preferred compared to the actual person, me, I mean"* ***(P33/L258-259)***
5. GEORGE	"*So my experience is that I can completely make sense of the patient's experience, which is usually in psychosis characterized by threat of some kind. So is an experience of stress or being subject to something, there is something that's invading them or they want to get rid off, they are constantly subject to something, that is something that I can easily relate to, understand and hold to be true"* ***(P5/L56-58)*** *"So if you truly allow yourself to immerse yourself into the narrative of someone with an inner psychotic episode, what you come out with is the experience of how they are relating to the world, or how they are situated in the world, how free or not free they feel there, and it's always internally coherent. I never actually worked with someone with a diagnosis of psychosis whose experience didn't have internal coherence"* ***(P5/L64-66)*** *"I do think that the construction of psychosis, the way it works in the society, indeed on a systemic level has used these people to differentiate themselves from madness. The role of the psychotics is actually to make the other person feel sane. That's what I'm trying to say here"* ***(P6/L84-85)*** *"At a more complex level, again my experience of working with psychotic people, they are putting together a story of why they are feeling tormented, haunted by life. Of why they are feeling that they have no clear boundaries about themselves, or why they are feeling that they can be invaded, or feeling that they have a hole in their skull which cannot close and things are coming in. Which essentially is a delusion of invasion or any of that kind; you can't shut off something in your head. Like someone left the window open that cannot be closed. Now if you take this as a metaphor, as an embodied experience of something that may have happened in their life that often rings true when you work with psychotic people meaning they often had boundaries violations or they had no boundaries at all. And they have merely formed a narrative about that"* ***(P10/L141-146)*** *"…so for most of the people I work with they live in a council flat and under very bad circumstances with no social contact, no meaningful occupation nothing to do in the day and to actually fantasize that there are people walking around the house who are interested in them is highly valuable"* ***(P11/L165-***

	167) *"So again my conceptualization of psychosis is a way of making sense of an internal emotional experience usually that is all it is, as anything as with other patients for that matter. It's not different. And it's a subjective way of going about it and usually there is some truth, which overlaps with life experiences. It is not all that mad"* ***(P11/L173-175)*** *"But the whole point I'm trying to make here it is about something, it's something about finding meaning in these things and understanding them intersubjectively. So for him the fantasy of a bottle that explodes was something that he brought in to test how far or close he can get to me, whether I could manage his madness, his anxiety and so on"* ***(P15/L249-251)***
6. JOHN	*"…I think the fact that he (p) rather than other approaches which were trying to sort of get rid off the voices and things like that and so on and supress them and so on, my approach was trying to in a way give the voices a voice, to speak so that they could be heard, and thought about…emm…understood and how they connected with his outer world and so on, outer world experiences…"* ***(P21/L148-150)*** *"So it's a question of just gradually making a psychological story that is useful to…rather than these strange bits of biology, and, totally explain it in biological terms. It's actually a psychological one. This makes sense in terms of his life and very…not just intellectually, way of understanding, but that the understanding was highly relevant to his real life issues"* ***(P22/L187-189)***
SUBTHEME 1.2: <u>THE IMPACT OF LIVED EXPERIENCES ON DISTRESS AND PSYCHOSIS</u>	
1. PAULA	*"…there is much clearer link to child trauma and neglect"* ***(P11/L43)*** *"I guess is about attachment experiences, I guess I'm always very mindful that for the most part the clients I work with had difficult childhood experiences, breaking attachments…"* ***(P13/L55-56)*** *"So then actually a huge history of neglect in childhood but he was able to form an attachment and to start to trust me and start working on all of those things"* ***(P17/L83-L84)*** *"…and she often, there were times when she was destabilized by environmental stimulus and stress triggers and things and she often behaves as she is a child"* ***(P20/L102-103)*** *"…but loads of attachments difficulties in relationships, family relationships that had broken down…"* ***(P21/L110)*** *"She has suffered severe neglect and some degree of abuse although that's not clear, so it's not so clear to work with but loads of attachments difficulties in relationships, family relationships that had broken down, she hasn't been able to maintain a job, so this fantasy is extremely valuable really"* ***(P21/L106-111)***
2. BARBARA	*"Even if they are smart, interesting, so it doesn't come to the expense of intelligence so it's not that. It is something interpersonal. Relationships break easily. And this might happen with other clients, neurotic clients, I don't know. See my main work is with psychotic people (laughs). So I don't know"* ***(P24/L94-95)***
3. BETH	*"…the main issue, that most of them had emm…was being very much isolated, so very in themselves, a lot of difficulty in emm actually talking and communicating and making relationship"* ***(P3/L24-25)*** *"I do believe that there's trauma. Most people who have psychosis had some sort of trauma, that is what I believe, I could be wrong. Emm…of course but, I check it out and ask, and often, and I've heard this somewhere"* ***(P9/L58-59)*** *"Emm…but that was what the diagnosis was. She was very, very isolated and most of the people there, those with the diagnosis of psychosis, who seem to be a bit more correct with their diagnosis,*

	emm…they were very isolated…" ***(P11/L76-78)*** *"And he became unwell, this is quite usual for most of the people I've worked with emm...became more unwell when his mother died. And he was living alone. And had then became very unwell. He didn't have other people around, his father had died and no family, emm...and he pretty much, emm...he fought with a lot of people. So shouted a lot, and throw things"* ***(P16/L129-131)*** *"…she was pretty much brought up in [redacted], in the psychiatric hospital, her mother, this is what we were told, because the history, you know there was nothing in her notes, we had no family to talk to, emm...so her mother had psychiatric problems. She was born in [redacted], then went to some sort of orphanage for kids, and anyway, in and out of [redacted], pretty much it was her home. And she came for pretty much three and half years. She was very, very aggressive when she first came, because she had learned to live, she lived with a man at that time, and subversive prostitution, and very severe, well I imagine very severe voices…"* ***(P19/L159-163)*** *"…Emm…he was somebody who had a diagnosis of psychosis, from about the age of twenty, emm…had very difficult background emm…and so I mentioned the trauma bit, he had been, he said he had abused kids, and had been in the prison for it, there's a question mark, as in whether this has happened and his family couldn't explain, you know, they oh yes, it has, or, very desperate family, so we couldn't actually get a proper, what had actually happened but he'd very like, to had been sexually abused by what he said. And he had been quite aggressive to his brother, he nearly killed him and he went to hospital for that, he hit him on the head with a sharp knife, emm…"* ***(P23/L238-242)*** *"…my feeling was that a lot of them had relational problems, so the common thing for me, they came from families who were either too much, most of them were you know there, but emotionally not at all"* ***(P36/L371-372)*** *"…and he was severely abused, my understanding was that it was more emotional deprivation, he described inappropriate sexual behaviour so parents having sex in front of him, and touching him…"* ***(P39/L390-391)*** *"…and was able to throughout our relationship, and the relationships he had with other people, in the apartment, he was able to, I think to be more open with himself, and learn to defuse situations and when he did have problems with people or people had problems with him, he was able to take some time and then discuss it with them, through the therapy..."* ***(P40/L416-418)***
4. CARLA	*"…if he's very close he's threatened with someone, if he's very far away again he feels that he is left alone. It's very, it's an antiphasis…"* ***(P4/L20)*** *"But I would certainly say that something, which is very common, is, well is the difficulties, the great difficulties in relating and distancing from others…"* ***(P6/L27-28)*** *"So, this person had a very difficult childhood, many traumas, his dad was abusing him sexually, his uncle also, his mum committed suicide, his brother tried to kill him when he was a soldier, so yes, very traumatic so far"* ***(P8/L49-50)*** *"I mean, again the difficulties, I mean he had difficulties in relating to all significant others in his life, he was very, very alone, and it was very sad for me. He went through so many different traumas in life, horrendous experiences and his psychosis exactly, this exactly was, his psychosis was developed in order to deal with all that"* ***(P32/L247-249)***
5. GEORGE	*"…fact they have indeed grew up in a situation where they were constantly subject to an experience of powerlessness and the absence of choice okay…"* ***(P5/L60-61)*** *"…the fact that people get sectioned and forced the medication often, if they are not consenting to treatment, but first of all the experience of being locked away by force, and force the medication, replicates the very metaphorical essence of paranoia. So we can say from a psychoanalytic framework, the services are spot on colluding with the defence, and acting out against it. So already if we think for example that there is a link between trauma, subjective trauma history for someone who develops psychosis, they are traumatizing a person, making them worse by having no freedom and choice. That experience, materializes by the moment you are sectioned, it becomes a reality"* ***(P9/L111-115)*** *"Which essentially is a delusion of invasion or any of that kind; you can't shut off something in your head. Like someone left the window open that cannot be closed. Now if you take this as a metaphor, as an embodied experience of something that may have happened in their life that often rings true when you work with psychotic people meaning they often had boundaries violations or they had no boundaries at all"* ***(P10/L144-146)***

	"I did a one-day contract with the [redacted] for the victims of torture in [redacted], and I got my second patient, which was a woman, who came in and I could barely see her face. Literally what had happened, she repeatedly had her face distorted by acid by a group of men" ***(P20/L358-360)***
6. JOHN	*"Nearly always people with psychosis have some disturbance in their relationships, interpersonal relationships, consequent of what's happening in their world which of course in itself might be consequent on problems of, in the outer world impinging on their inner world so it's a circular issue"* ***(P7/L22-23)*** *"In summary I see everybody having varying degrees of vulnerability and facing life, facing life issues and we all have ways of circumventing, we all get tripped up when too much are happening and in the person with psychosis, they've usually had, a person who is having more acute psychosis, person has had either a or a series of things that have happened in their life, or not have happened, it could be disappointments, or failures that have overwhelmed their mind's capacity to cope and emm…in my way of thinking this are much more affective experiences than cognitive experiences or the cognitions get disturbed as part of the process. But I see psychosis primarily as an affective disorder (p) although the way they've seen the world preceded psychosis will obviously have cognitive aspects. I do see nurture as having a very big role to play in the vulnerability of psychosis"* ***(P8/L35-40)*** *"Yeah, and suspiciousness of course, I mean I suppose that's got an affective component, being suspicious and not trusting people. That's obviously a feeling aspect to it. So the paranoia obviously, suspiciousness and lack of trust, emm…is a very common feature"* ***(P10/L55-56)*** *"People with psychosis have the difficulty in sustaining a relationship. That relationships readily break off, so this, so that's (p) emm…"* ***(P11/L60)*** *"…and he was always on some kind of guard that he was going to be subject to something shameful humiliation, picked on him in some way, repeating a lot of his history, so he couldn't sustain these kind of relationships with people, with peer groups"* ***(P19/L137-138)*** *"Affect was in the voices. And of course as well as having being on the receiving end of a lot of cruelty and humiliation, it meant he…quite detached from many things, in which he could own his own capacities to humiliate or be…actually be violent to others in the face of humiliation"* ***(P22/L177-179)*** *"…what comes to mind is that these patients are often very much on their own, which is both a source of safety and a great pain to them, existentially alone"* ***(P28/L235-236)***
SUBTHEME 1.3: LOOKING AT SELF PROCESSES	
1. PAULA	*"…disintegration of somebody's thoughts, sense of identity but also the being"* ***(P7/L22-23)*** *"Emm, I guess there is a very disrupted sense of self. Sense of identity really that people are lacking, a coherent story about themselves, who they are, apart from those experiences"* ***(P9/L30-31)*** *"Certainly the way that I see that are not being able to construct meaning out of the psychosis experiences, so explicitly on psychosis but also of their sense of self or past experiences that they may had and not sort of linking back together again"* ***(P12/L47-48)*** *"There is too much discontinuity and it's impossible to put the links back again and that she has a coherent sense of self or how I would like her to have"* ***(P12, L47-48)***
2. BARBARA	*"I would consider that the build-up towards it will be that some sort of gap started in terms of who they are and the direction of their going and then it was too much so they got psychotic"* ***(P16/L53-55)*** *"…and he was saying I'm, I don't know...stories that his personality was taken from him. So there is something about not having...emm...I have now a client not being able to hold on to something"* ***(P23/L86-87)***

3. BETH	*"…especially with people with psychosis, I find it very difficult for them to understand that the other person has a different view from them, or you know, the theory of mind was a little difficult. The point that someone else is thinking something else or you know, they are not trying to hurt them, yeah. Separate from them and that sort of thing"* ***(P5/L39-41)*** *"Basically yes I do believe that most of them probably did have, do have problems with their sense of self. Some of them anyway, and they had difficulty separating their self from others, I imagine they have difficulty separating themselves from others but they seem very separate from others. So it was perhaps part of them trying to separate themselves from others, they have relational problems"* ***(P36/L368-370)*** *"…that some people with a diagnosis of psychosis would sit in front of a mirror, and look at themselves a lot. And I was told, oh people with psychosis have difficulty with mirrors and they shouldn't have mirrors and they sit and look at themselves in the mirror. And I thought, I'm wondering why are they doing that. My hypothesis is that they don't know what they look like. Not really, but what I mean is that they have no sense of themselves, or a little sense of themselves…"* ***(P37/L378-381)*** *"And he was someone who had to me a very underdeveloped sense of self…"* ***(P39/L394)*** *"And yes, to me it was working, getting him to develop slowly his sense of self, by me reflecting what I see…"* ***(P40/L408)*** *"He was brought up pretty much, this was how I understood this, and him and his mother was the same thing. So we worked together how to develop his separate sense of self"* ***(P40/L417-418)***
4. CARLA	*"The person is also fragmented, his internal world is fragmented and into several pieces which he…its difficult for him to put together. Yes, this disorganization and fragmentation is of vital importance"* ***(P2/L13-14)*** *"And this is because of the difficulty, often, in differentiating themselves from others, some basic boundaries, yes are not there. So they have a fragmented sense of self, yes, their identity is not whole, constantly disrupted. And it is threatening for them to come too close but threatening if you stay too far away from them as well"* ***(P6/L28-30)*** *"Careful to allow them the opportunity to develop a more stable sense of self. A sense of self, which is not solid but stable enough in time. And you know, when you come too close to them in many ways, even physically is, yes, it is difficult for them emm because they merge with you and they take the relationship as one. The purpose is to help them to develop their autonomy and obviously before autonomy precedes dependence"* **(P12/L72-74)** *"I often find myself having to be more flexible but careful at the same time, because as I said before, or I didn't, did I say about the boundary between self and other? I did yes, so often for the psychotic this is not there"* ***(P11/L69-70)*** *"And from there on we were able, and I must say that also with this patient, the issues with self and me, the other if you prefer, and making the difference were and still are there because we are still working together"* ***(P33/L262)***
5. GEORGE	*"…to challenge their thinking and to realize what I am experiencing may not be what somebody else is experiencing"* ***(P12/L184-185)*** *"And I know that someone might say is dangerous, is without boundaries, but there again in the context of our interview, what people don't often seem to realize is that by definition, a psychotic has no boundaries. There are not there. There is no separation between them and the world"* ***(P21/L407-409)*** *"As I said, what you get with psychotics is that they don't differentiate between that. Again because their experience is that of having a hole in their skull, there is not separation between them and the world anyway. It's like, it's a constant flux"* ***(P29/L540-542)***
6. JOHN	*"Because well as you know, well sometimes there can be great confusion or loss of boundaries as one of the common features in the more severe psychosis a lot of being unable to differentiate between self and other, (p)…"* ***(P14/L90-91)***

	"…try to blur the boundary between us, or locate something outside of our self which really belongs inside and so on…" ***(P26/L225)***
SUBTHEME 1.4: <u>UNDERSTANDING INFORMED BY HOW THERAPIST IS AFFECTED</u>	
1. PAULA	*"Sometimes the client has too much and sometimes once we start making some insights and the attachment gets too strong the clients would tend to back off more, avoiding me and me noticing that. With another client group I might be more challenging in terms of working with that, with this client group I might be more aware of it and allow it to happen to some degree by trying to hold something about, about them and what that tells me about formulation and understanding something about their difficulties…"* ***(P15/L67-70)***
2. BARBARA	*"…emm…she went from foster house to foster house and she is very…very…spoilt. Emm she is very hurt…and she is sweet…very very sweet. And she creates like people want to adopt her. No, I don't want to adopt her, I have my children and I don't want to adopt her. I wouldn't take her home. And I brought that to supervision. Now this was me talking...with my issue, in front of her, and see the way I felt, rejecting her in a way helped to understand about her own difficulties…"* ***(P46/L204-207)***
3. BETH	*"We had very few histories, from people. So it is very difficult from me to know exactly, my feeling was that a lot of them had relational problems, so the common thing for me, they came from families who were either too much, most of them were you know there, but emotionally not at all. They basically had no one to, so no one reflected them, no proper communication no proper reflection, there was someone there giving them food, giving them money, but that was that, no sense of, you look nice you look beautiful today, you know no reflection. So to me the sense of self that some people didn't have was to do with that. That someone was there but it wasn't there. So a parent brought them up but it wasn't present. But that was the feeling because of how I felt in the relationship"* ***(P36/L370-375)***
4. CARLA	*"So, when he is paranoid that I can read his mind, or I know what and how he is thinking about me or anything else, I understand it as, I try to (p) yes, I try to find my position in there, I mean my own responsibility let's say. So yes, when I'm keeping my distance for this and that reason, to protect myself I understand the why and how for him. I have noticed that when I keep an emotional distance from him, he gradually becomes paranoid"* ***(P20/L151-153)*** *"And how the patients affect me, says a lot about how I understand what they are going through, and, yes, also what their psychosis is all about. And how I am affected, you see, says as well a lot about my, (p), yes my own difficulties"* ***(P21/L161-162)*** *"I have to make sure often, that he knows what I am thinking and how his stories impact me, and tell him, that, yes, that emm…that this is me and this is you. And I would say things like "you look like that'', or "it seems to me that'' you get what I mean, yes, as I said earlier, how his stories impact me allows me to understand him"* ***(P33/L263-264)*** *"But yes, with this patient the connection is strong, and it is important because, this is exactly why, I mean it is why we are able to understand his delusions, that why they are meaningful"* ***(P34/L276-277)***
5. GEORGE	*"That is the essence of working intersubjectivity. Take his experiential world, bring it into the intersubjective space, and in fact we may have different approaches to it, but using that space to connect me to the person, and how it impacts me tells me what might be going on with them, to then allow them to open their mind further"* ***(P21/L394-396)***
6. JOHN	*"Emm…my spontaneous response is that it can come in two ways. It can be, it can come across as a, as a lack of affect, a sort of split from affect, so the relationship is very dead, emm…(p) and I will experience this to my bone"* ***(P21/L394-396)***

	"…but he couldn't be able to make any playful gestures with his child and we got quite frustrated and thought we couldn't understand what was actually happening and found ourselves getting down on the floor and playing with the child, with the toys that were there and so on, making noises with the fire engines and airplanes and this and that and it was great to get laughter from him. And afterwards we, me and my colleague, we were reflecting on this and thought my God I'm going back to the clinic and say that a I had been playing on the floor with children and so on, I'll be very ashamed and humiliated and you know, what the hell are you doing and that was the important clue. We got to what was his problem. That, and that really helped. A really good understanding of him…" ***(P21/L394-396)*** *"The degree of anxiety or feelings informed me, was very helpful and informed me about the patient's subjectivity"* ***(P21/L394-396)*** *"The case when one's responses parallel patient's but in this case was such a powerful feeling and that's why I put it together and it told me something about the patient. Suddenly it made me feel much more close to the patient"* ***(P21/L394-396)***
MAJOR THEME 2: A RELATIONAL APPROACH TO THERAPY	
SUBTHEME 2.1: PRIORITISING AND MAPPING RELATIONSHIPS	
1. PAULA	*"I am able to offer them a different type of relationship and I see that as having some value really. Its often not about recovery or change in the same way as I see it with other client groups. Sometime is about being there for the client being able to offer a different sort of relationship that they can learn from"* ***(P13/L58-60)*** *"Actually coming back to think about attachments. Sometimes the client has too much and sometimes once we start making some insights and the attachment gets too strong the clients would tend to back off more, avoiding me and me noticing that"* ***(P15/L67-68)*** *"But certainly there is [P] I think there are different ways in which she will be using this fantasy in that relationship and how she understands my role and my own involvement with that. So she might be defending not to get close and also [P] how she sees and makes sense of me"* ***(P23/L121-123)*** *"And it was I guess this was something that we talked not only with me but with the team as well and how he related to the team generally, that he would engage and form relationships and to open up about his experiences and then he pulled back. So it's about sort of noticing that with him but also allow it in a way rather that pushing him and challenging to the degree that he needs to engage, that he has to think of that and that enables him to continue to work with me really"* ***(P17/L87-90)*** *"It would come up in the process. Noticing patterns, the here and now statements and what happens between us. So for example I've noticed that we get pulled in a fantasy, the formulas again"* ***(P38/L178-179)***
2. BARBARA	*"…it's better to talk about the there and now, so it doesn't have to be about the there and then, so it's like what's happening within the unit, with the other people, before we speak about our relationship, or go on, on self disclosure…"* ***(P14/L41-42)*** *"…I am going back to the one I know for a long time, and there was a whole…that he would say, you know, every now and then would say "no, we are talking about what you want, not what I want". And it kind of, and you need the connection in order to respect that, and follow that, and work with it, and not see it just as resistance…"* ***(P66/L318-320)*** *"…only like two weeks ago she said "I feel like I want to talk but I don't manage to do it". Ok, she*

	said that a few times, few times lately, quite a lot of times before, but only two weeks ago I understood that she means that she failed me, she disappointed me. So I feel like I need to talk, but I don't manage to do it, I feel like I should talk, I should be a good client, I should talk and I don't manage to do it. So that after nine months (laughing). I think I understand what she says. It's more…yeah" ***(P70/L344-347)*** *"We have another six months, so we have started talking about it now. On the last session, the last, last session, it was really, almost kind of talking about that, you know, talking about us, what's missing, what's not there"* ***(P81/L410-411)*** *"But for me, the main work, and she did, and she is in a very different place now, and the main work was, with her peers. So she had very very intense relationships with other girls, and there is another girl, a close friend, and we were looking at that connection. We were sort of observing what happens for her there and looking at it"* ***(P81/L415-417)***
3. BETH	*"…but the relationship is so important, and especially for these people, not so much with people in disabilities, but with people with psychosis. It's so important to be able to make a relationship to, make relationship with themselves, in order to be able to relate to somebody else. Yeah"* ***(P3/L26-27)*** *"So I work very much with how I feel, you know with the other person, countertransference emm…and how they behave with other people…"* ***(P5/L33-34)*** *"What I, what I consider very interrelational, emm...is, I, use myself a lot. And, and the work. So, my relationship with them, you know, how they view me, or how I view them, emm…or you know, when they shout, how I'd feel, or you know…"* ***(P15/L111-113)*** *"So, emm...trying to be as present as possible with them when they were there. So I would, you know, bring up you know, on occasions when I thought was helpful, a feeling, you know I was whatever, how they made me feel, and always explain why I did it, so they can understand that by, by, by bonding with me, or you know, emm...creating a relationship with me, that way would also create a relationship with themselves and be able to create relationships with people outside. So that kind of, I, yeah, consider interrelational, and let's say intersubjective"* ***(P15/L115-119)*** *"…emm...and very much on sort of management of relationships. So if he had difficulties with people out, you know, outside of the room let's say, outside you know, in the residential home, which he did have a lot of difficulties, we would you know, talk about that, but also I would any, any opportunity I could, you know grasp, I would used to, how do you feel with me, what do you think I'm thinking, emm...this is what I feel, emm…"* ***(P19/L149-151)*** *"…that basically there is a reason people are doing whatever they are doing and he was you know, a responsibility for the relationship, for what had happened between me and him. I had responsibility and I don't often become angry but when I did, I did express it a bit because I thought it was very important for him to understand how someone else feels…"* ***(P23/L231-233)*** *"…but you know, this, I really also took into account how he related to everybody else in the residential home…"* ***(P23/L258-259)*** *"...and was able to throughout our relationship, and the relationships he had with other people, in the apartment, he was able to, I think to be more open with himself, and learn to defuse situations and when he did have problems with people or people had problems with him, he was able to take some time and then discuss it with them, through the therapy..."* ***(P24/L290-292)***
4. CARLA	*"The therapist tests his abilities a number of times and this is something that puts the relationship, transference and countertransference on the spot"* ***(P1/L3-4)*** *"And I was losing him, and he was losing me. But we both tried hard you see. We were both part of this, and it was difficult for both of us. I actually think that it was more difficult for myself for a while. But when I said, because I did, I said to him how it was difficult for me, obviously I was, yes very, very careful how I said what I said but yes…"* ***(P17/L115-117)*** *"…we take his disconnection together and slowly, slowly explore it. And what often happens, which is in the context, I mean in working and considering intersubjectivity, the disconnection is found and, yes, found in the between us, so it is explored within the context of therapy, not only, because of course you, we explore, yes, other significant relationships, but our relationship is vital, and it happens right there, there, so yes, we take considerable time to see what happens between us"* ***(P19/L142-145)*** *"I mean, we were exploring, his relationships with other people, his father and the dead mother, of course, yes, but I was finding it difficult to invite him to explore what was happening between the two of us. It often felt to me, very often that if I go closer something terrible would have happened…"* ***(P32/L249-251)***

5. GEORGE	*"I asked him why it was important to have explosives in the session. And then he said I just wanted to simply see how you would react to this. And then I said I am mostly intrigued. And then I said something around, I wonder whether it's important to know you can blow the situation up if it became too much. He said yes, that would actually be quite helpful, but it is actually just water. So I said I get that. But the whole point I'm trying to make here it is about something, it's something about finding meaning in these things and understanding them intersubjectively. So for him the fantasy of a bottle that explodes was something that he brought in to test how far or close he can get to me, whether I could manage his madness, his anxiety and so on"* ***(P15/L247-251)*** *"We went from there and in the end we managed to get to what was really at hand, which is putting boundaries in relationships. There have been none with his relationship with parents. They were still in contact irregularly, and when unwell they would call him, every three weeks, and getting so annoyed that he would throw his phone and broke it and step on it, and then he had to buy a new disposable phone, which is quite expensive for him because he's on benefits but it was his only way of disconnecting. So rather than being worried about that, we thought about different ways of disconnecting"* ***(P15/L270-273)*** *"And I would comment on people's capacity for proximity. I would say things like "It feels like you can't let me in there" or "it feels like I came too close" or "it feels like you want to come closer to me"" (P29/L534-535)*
6. JOHN	*"So to some extent the most important thing is, I think building up a sense that you care, actually that you care about them and you recognize that they've got long term vulnerabilities even though that might be painful for them to acknowledge that, and that as far as possible you are there for the long term"* ***(P11/L64-66)*** *"…with more time, the voices could be more integrated as a meaningful part, not just of his inner world but also in his intersubjective world as well. Relationships are real, important issues. Vital to his future. To be able to be managed, and work with them"* ***(P22/L191-192)*** *"…so I asked him, what was the worst thing that can happen today? So starting from…so what's the worst thing that I could do to you? So he was able to say that he was terrified that I was going to put him into the hospital. So I allowed him for me to be the worse person or that person that could do the worse thing he could imagine. And working the between"* ***(P24/L204-206)*** *"Or what's the consequence of me having not done this, or said this, on, on, the relationship between us. So, I mean I suppose, a simple answer is in a way being prepared to voice out what's happening in the interface between us. If there is something which needs thought" (P26/L219-221)*
SUBTHEME 2.2: <u>THE USE OF FIRST AND SECOND PERSON PERSPECTIVES</u>	
1. PAULA	*"…he would engage and form relationships and to open up about his experiences and then he pulled back. So it's about sort of noticing that with him…"* ***(P17/L88-89)***
2. BARBARA	*"…and today you know when we were going towards the end of therapy he knows exactly how I feel towards him. He knows the difficult times; he knows things that now we can talk about it freely and about the connection between us and that's because it was there all along. You know it didn't just happen. I made a few times a conscious decision..."* ***(P32/L128-130)*** *"These are things that I still grapple with. I think I bring more and more of myself into the therapy room"* ***(P43/L189-190)*** *"So I would bring my opinion, I would bring the way I perceive sometimes the way I...feel about them, later stages, I can also laugh sometimes when it's not appropriate, I blush, I can emm...become sad, show it, and talk about a mistake I did last session. But this is all...this is all, with the idea...even if it's not deliberate, it's towards them. Trying to be...sometimes I would also take a conscious decision not to bring some things. Or what's difficult for me in the relationship with them, sometimes is not the right time for them to know. Maybe later on, but that would be delaying it"* ***(P48/L225-228)***

	"…but for me was also connected towards the relational approach. I really see the connection there. And for him to really know what I feel towards him, to be aware of what I think about him and how I am with him" ***(P53/L247-248)*** *"That's the place that I can possibly connect with…or I can talk about myself and see how it translates to her, and I can't speak from her end obviously, but I can say how it echoes, but I can speak about myself and then see if this, something I said about it works"* ***(P84/L432-434)***
3. BETH	*"…I suppose it's a person-centred word, congruence. Emm...or let's say presence. So, emm...trying to be as present as possible with them when they were there. So I would, you know, bring up you know, on occasions when I thought was helpful, a feeling, you know I was whatever, how they made me feel, and always explain why I did it…"* ***(P15/L115-117)*** *"I had responsibility and I don't often become angry but when I did, I did express it a bit because I thought it was very important for him to understand how someone else feels…"* ***(P23/L232-233)*** *"…and expressing all, I'm sad, I feel sad that you are hearing these voices. Must be very difficult"* ***(P19/L177-178)*** *"And, the main work I did was reflecting and bringing myself fully into what was happening. He would be like "oh so you're thinking this, and you must be thinking that" so very paranoid, a lot of paranoid thoughts"* ***(P39/L395-397)*** *"I will start with the reflection bit. He was someone who, I will basically say, you know reflect something, or talking about his positive bits, and really he wouldn't believe me, and I would sort of, you know when you say this you look like this, and you know when you look anxious you are doing this, or whatever"* ***(P40/L401-403)*** *"…and I kept on saying well you know, I can see someone who is feeling anxious and you know I can see that from your brows, or from your sweat or you know because I was trained in that way. Or your eyes are doing this and your face looks a little bit more red, looks you've got more blood in your head, you got emotional or whatever, or you're anxious. And yes, to me it was working, getting him to develop slowly his sense of self, by me reflecting what I see and slowly, slowly believing what I was seeing…"* ***(P40/L406-409)*** *"…so with this last example is that I used myself more than I would with someone else who hasn't got so many paranoid thoughts. I brought more of what I was thinking into the play. So yes maybe I use myself a bit more with people that are more paranoid"* ***(P44/L454-456)***
4. CARLA	*"I would let him know how I am affected by his stories, his feelings, their, yes (p). Because it is very important to let him know how he affects me, and us, the dyad, he hasn't learned that so far in life. If he knows how I am affected he is more able to understand his own position between the two of us, I'm not sure if you follow?"* ***(P18/L132-134)*** *"But when I said, because I did, I said to him how it was difficult for me, obviously I was, yes very, very careful how I said what I said but yes, he was very cooperative…" (P17/L117)* *"So in this cases, I need to find all the possible, yes possible ways to let him know that I have my own mind and, and I am processing things differently than him. So, yes, I would talk to him deliberately, I mean I would do a lot of mirroring and describe to him what I see, and how I see him, and what I reckon he is experiencing etc."* ***(P19/L140-142)*** *"…so for example he will say something about his mother who killed herself or something about mothers generally, or anything and it might sound very psychotic and paranoid, so I will tell him how I honestly feel and think about it. Which often, yes, there is trouble with this but I have to, yes"* ***(P22/L174-176)*** *"Everything was different, I was more transparent, more available, and you see, I was open about this, I felt that I had to let him know that I felt different and told him about my way, of, of (p) my understanding anyway of the relationship changed"* ***(P33/L260-261)*** *"I have to make sure often, that he knows what I am thinking and how his stories impact me, and tell him, that, yes, that emm…that this is me and this is you. And I would say things like "you look like that'', or "it seems to me that'' you get what I mean, yes, as I said earlier, how his stories impact me allows me to understand him"* ***(P33/L263-264)***
5. GEORGE	*"…and I have worked at an interpersonal level with them that other people would have been mortified by, including things like self-disclosure, not traumatic things about myself, not anything about my life*

	background, and so on, but be able to say that of course life it's maddening at times, that feeling is reality…" ***(P9/L127-129)*** *"I use my own response to the person, the patient, to inform what I think is going on with them, I sometimes use my own reaction to them to help them to make sense of experiences, which with some psychotic people can be helpful because they often have no awareness of the impact they have on others"* ***(P14/L216-218)*** *"That is something I do, and I would sometimes share that experience. I would say, it is, my felt sense of you is like that. This is what I feel you are experiencing. I do, do that immediately with patients to build up a connection…"* ***(P19/L340-341)*** *"…be really transparent and explain why I do what I do. So I would say I'm putting this out here, and this is how I feel and we can look at it. It doesn't mean that I want you to feel this, or this and this"* ***(P22/L421-422)*** *"In a very basic nutshell is me turning out what I believe they are experiencing. And offering this on the plate. As in, I'm sorry I am offering plate you probably cannot see it. So this is what I think you're experiencing here, look at it, if you can relate with it, let's go there together, I would go with you. Let's go into his feelings, let's go into the experiences. That is the essence of working intersubjectivity"* ***(P21/L392-394)*** *"…something I think that works very, very well with people is mirroring, it's just reflecting back to them what is going on so that they can see that you can see it. Which is hugely rewarding for them. So that's an intervention I would say I do intersubjectively and it helps a lot"* ***(P21/L403-404)*** *"And I would comment on people's capacity for proximity. I would say things like "It feels like you can't let me in there" or "it feels like I came too close" or "it feels like you want to come closer to me"* ***(P29/L534-535)***
SUBTHEME 2.3: <u>THE FLEXIBILITY OF BOUNDARIES</u>	
1. PAULA	*"But it felt that it was a huge thing for him to start to open up all of those details so he would...he back off and then he would engage and my team allows the possibility for that, than I am there available. I mean in the team we hold a caseload of 100 clients that would disengage and engage again. So he disengaged and said he didn't want to work anymore but then he wanted to come back in and wanted to reengage with psychology"* ***(P17/L84-87)***
2. BARBARA	*"So they have somebody who is in charge, like an occupational counsellor, in the unit there are social guides or social counsellors I don't know what to call them, they have therapy twice a week with their personal therapist, groups and all kind of other things. So we see them twice a week for 45 minutes. And then in the kitchen, and in the field trips and in parties etc etc etc. But that's our time with them"* ***(P40/L173-176)*** *"…I tried to contact her and she wouldn't talk to me and then she cancelled and the day before meeting she harmed herself very severely and she said I was really...emm..and I took her to the hospital, and they wouldn't hospitalize her and we had to spent together 8-9 hours so we had a long time (laughs) to talk about things emm get (P) emm but that was, that was leaving my role…"* ***(P46/L209-212)*** *"...and I think that loving them as clients is the caring part, it's to enhance what I believe it is good to enhance, to change, and yes I...(P). I...you know, I am looking to change people. I am thinking that possibly to love somebody as a person you don't really...you need not to be focused on changing them but as for clients then yes..."* ***(P37/L157-158)*** *"And then there are times that I start to get jealous of the guys who spent more time with them. And they can just talk to them, you know be with them and get something that…emm…(P). Of a different, like more like person-to-person rather than therapist to a client. Obviously for the guides are still a client, it's still not friendship. It's different"* ***(P41/L179-182)*** *"...you know to, to get to know them outside…well not just. To get to know them outside the therapy*

	room and I imagine to get them to know me in different set. Kind of like. And they are very young (laughs) but I can see how my younger self could be their friend emm sort of like how I could (p) have them…well my kids are very very young so they are too young but how I could have them as friends of my kids. Something that is not just sort of clients" ***(P42/L184-186)*** *"As a person or as a therapist? Because it's not the same thing. Because I think (P). As a person is like uncovering your vulnerability to any other person, so you make yourself more vulnerable and it kind of creates you know…lowering defences and it's the same as gaining and loosing from relationships in general. As a therapist (p) I think that I'm sort of exploring now, occupied, preoccupied by…is…I think you can do…you can show all kind of aspects of yourself as long as is in the service of the client. As a therapist to create something that is outside, to abandon this position of the therapist I think it would be misconduct"* ***(P44/L195-198)*** *"A professional love towards them. So no need to love them as persons but that I need to love them as clients. So, I know, I don't think it's interfering with my countertransference because I can still...they can still annoy me and I can still hate them at the same time but I feel, for me the first stage of therapy is to find this and if I can't find it then things get very difficult. It becomes difficult when they don't enter your heart, sort of becoming a significant other for the treatment, becoming something that I can...that I want to work with, feel connected with"* ***(P36/L149-152)*** *"My role in our unit it's not just the psychologist. I am also a case manager. So, I'm also, should be, not always but I should be in contact with the occupational counselor, and the guides, the psychiatrists, and the dietitian, and…when it's time to move a stage, you know, every 3-4 months, I do case presentations, so we are very involved in their life. With their parents, and there are parents' meetings at times. So we are very involved in their lives"* ***(P81/L418-420)***
3. BETH	*"…for most of the time we worked with, I saw him about 3-4 times a week, which is very unusual, it's not something I do. Emm...I don't work psychoanalytically, but because he was, he would come up with thoughts and suicidal thoughts and it was probably more to keep my attention going, but it was a way of relating…"* ***(P16/L132-134)*** *"…so he, we organized that he, you know spent half a day working in the kitchen, with the cook. It was very unusual, it wasn't something, you know, they did there because they were scared, he had actually done four suicidal attempts, and one of them was with a knife. So we were extremely worried about him. But he has, that was quite a long time ago, we were, we were ok about him doing it. Emm…about him going into the kitchen, that's what I mean, and using a knife. Anyway, so we organized this, and I was part of organizing it…"* ***(P23/L216-220)*** *"...you know how very helpful it is to be more present, and bring yourself more to the relationship and because we didn't just do therapy together, we, I also go for coffee with the other residents, which is part of them getting out in the community, and we also go to meetings for them, to find a job, or going to a group, or to the theatre, so my role isn't just to do the therapy and go. They see me in other realms, so we sit in the kitchen and have a coffee, and then we do therapy"* ***(P24/L275-277)*** *"…and I had this thought of bringing a mirror so that he would look at himself. Anyway, I didn't go ahead with doing that but I actually took him out of the room and had him in front of the bathroom mirror, so we did quite a lot of work with reflection. It isn't something that I have done before, in the bathroom in front of the mirror, but I do think it was helpful. He didn't believe what I was saying. He was very stuck with the thoughts he had, that he was very ill and he was very psychotic, and there was something wrong with him and I kept on saying well you know, I can see someone who is feeling anxious and you know I can see that from your brows, or from your sweat…"* ***(P40/L403-407)*** *"...he developed a bit of an attachment to me, and although I explained that I was married, and you know, the sort of, roles that I have, the different role, how he can form a relationship with, how he can do that, and that sort of thing. He had, you know, he had considered that we can have a relationship, so I have explained very clearly, so this thing was very present, that I wasn't interested in a relationship with him, and why, and yes, this was too much for me, boundaries were shaken, and so, and this was, intruding"* ***(P23/L262-265)*** *"So yes, although I was anxious about, about us having a rupture in the relationship, I wanted to be clear and I didn't worry that I was probably, not quite unbounded, because I come from a, my training is quite psychoanalytic, the doctorate had very much boundaries, and how much you use yourself, I mean I have done other trainings, a lot of work with myself, you know how very helpful it is to be more present, and bring yourself more to the relationship and because we didn't just do therapy together, we, I also go for coffee with the other residents, which is part of them getting out in the community, and we also go to meetings for them, to find a job, or going to a group, or to the theatre, so my role isn't just to do the therapy and go. They see me in other realms, so we sit in the kitchen and have a coffee, and then we do therapy. So, there I was worried about, always worried about, the boundary thing, I was trying to be as clear as I can, and be open, listen to, if he was angry, I don't know, I was, because I will be in therapy but also, other than that going out for coffee..."* ***(P24/273-278)***

4. CARLA	*"See, even though I am psychoanalytically trained, and I am very careful with boundaries and all that, and yes, I do know how important are, with a psychotic the story is different. I mean, yes, what I mean is that the process is different and the therapist creates the boundaries in different ways compared to other clients. I often find myself having to be more flexible but careful at the same time..."* ***(P11/L67-69)*** *"So, he came and asked for an earlier session and at the beginning I said, "no, no, we have in two hours time I would see you then". And he banged the door again and again, the third time I gave up. I said "Ok, I'll see you an hour earlier than the session" that, the, and I could smell trouble. Ok, so I did that consciously, thinking that Ok, this is an in-between solution…"* ***(P23/L180-182)*** *"…and I remember that I did take it from his hands and put it here, I sat down and I said "Now this is well protected. And I think that we can do something about you as well". That was all I said. But I did things, Ok. I was, I even touched his fingers maybe, I can't remember to be honest. But again, with psychosis you need to, I mean there must be flexibility"* ***(P24/L192-194)*** *"Yes, responding, but also moving inside this room maybe either frightened him a lot that I was losing it, because I was out of my usual way of working or was a response that also was responded not only in the real respect, you know, putting it here and in the symbolic respect as well…"* ***(P25/L196-197)*** *"You see, the settings someone works in are very powerful. I mean, yes, so I see the patient outside of the therapy room, because I can't and they can't avoid it. And sometimes it's helpful but other times no. So the boundaries are different, change, and on the other hand you can't do something differently. Working with psychosis needs to, someone needs to be prepared to challenge their boundaries, yes, I mean you can see from this very example"* ***(P31/L230-233)***
5. GEORGE	*"I have in the community in the NHS broken about every rule in terms of therapy that you are not supposed to break so often worked in people's homes, because I found it gave me a concrete insight into their lives, into their life world, and I have worked at an interpersonal level with them that other people would have been mortified by, including things like self-disclosure, not traumatic things about myself, not anything about my life background, and so on…"* ***(P9/L126-129)*** *"And because he had such a sense of disempowerment, I agreed with the care coordinator and the psychiatrist that I was going to get him dentures…we had already spent hours getting there because underground was not an option, we took the bus and I had to sit next to him on the bus and there was a promise, and while on the bus we had an agreement, we had to talk about horror movies because for whatever reason this made him feel safe. So we were on the bus, talking very loudly about horror movies…"* ***(P15/L253-259)*** *"One thing I just realized is that I need a cigarette. Something I have done a lot with psychotic patients, we smoked together. And many colleagues of mine would go "you cannot do that". I find it tremendously helpful"* ***(P31/L570-571)*** *"As a controversial statement I quite happily live in a world with psychotic people on the street and would find it much more enjoyable, and indeed often have asked me, are you not afraid in going in such a person's house and work with them? No I'm not"* ***(P34/L591-593)*** *"I was working with someone on the same unit and we had put what we called the sensory room, so that was about very primitive stimulation, so through light, through music, anything that was for embodiment soothing, and I had a very disturbed patient who could not at all manage the interpersonal proximity because there was too much confrontation. So with him I would work in the dark, he'll be laying on a bin bag in one corner of the room, and I would lay on another bin bag in another corner and I would switch off the lights so that he wouldn't see me. We would talk and it was going perfectly well"* ***(P34/L595-599)***
6. JOHN	*"That you (p) it means, to, not to a masochistic degree, but organize your life in an appropriate professional way that patients don't suffer too much from your own other issues in your own life, being reliable and so on. So (p) and I think being prepared for times when things are very difficult for patients. You know, you can't control everything with a psychotic patient, you can't control, and limits over the therapeutic process. Things happen in patients' life so a degree of flexibility is important, that's more so than you would with a non-psychotic patient, in being flexible in ones arrangements, ones responsiveness and so on…"* ***(P11/L67-70)*** *"…sometimes a spontaneous gesture in which one does something outside of the norm that can be helpful. I don't do this in a planned way, but I can remember working with an asylum seeker patient with psychosis who had, who was very on the edge…emm…and I think she was pregnant at the time and suddenly there was a crisis and she had to move at the weekend, and having got any sort of facilities and no money and things like that and I found myself with the care coordinator actually physically helping her move some heavy, you know washing machine you know things like that from one thing to another, and that meant a lot to her that I was prepared to do that"* ***(P12/L77-81)***

	"…one day I went for a walk with him for a session, and I can't remember the circumstances that provoked that but just seemed the right thing to do, talk to him in a less formal setting and that meant an enormous amount to him. It had reduced…that he can do something normal with me and that I was prepared to come alongside him. So there are sort of practical times when, when obviously you have to be quite thoughtful about this and reflect about it and so on because you can end up feeling pressured and being something that you can sustain and it's perhaps not helpful to sustain but this gesture I think means a lot to patients, who have lacked that experience of having a genuine, people being out there for them" ***(P13/L83-87)*** *"…but he couldn't be able to make any playful gestures with his child and we got quite frustrated and thought we couldn't understand what was actually happening and found ourselves getting down on the floor and playing with the child, with the toys that were there and so on, making noises with the fire engines and airplanes and this and that and it was great to get laughter from him"* ***(P14/L100-102)***
MAJOR THEME 3: THERAPIST'S PROCESSES IN THE RUPTURE OF RELATEDNESS	
SUBTHEME 3.1: <u>SENSE OF AUTONOMY THREATENED</u>	
1. PAULA	*"I think it makes me back off a bit. Probably, erm even to a degree, it might sound extreme but sort of dissociate a little bit. I guess I see myself from as her. Finding it very difficult to make sense of what I am sort of seeing. I guess I feel something's thrown at me"* ***(P28/L141-143)*** *"I guess there are moments of reflection and challenge and quite recently I had a quite significant reflection with somebody about them acknowledging how they had a fantasy that I could look after him. And that was sort of a replacement for someone they worked in the past with whom they had a good relationship with and then he experienced the loss, and then that I am not always going to be here and I can't actually do that. That as much as other people have let you down and rejected you I will too. And to be able to sort of sit with that"* ***(P56/L264-267)***
2. BARBARA	*"Emm she is very hurt…and she is sweet…very very sweet. And she creates like people want to adopt her. No, I don't want to adopt her, I have my children and I don't want to adopt her. I wouldn't take her home"* ***(P46/L205-206)*** *"No. No. All I said is that I am not a hugging person etc. When we talked for the 8 hours no. I kind of understood that this is not what I can bring to her, at least not at this stage. This was too much for me, it was already an intrusion"* ***(P47/L214-215)*** *"If what was going on is the lack of connectivity and I feel threatened possibly by it, then I'm tensed"* ***(P94/L486-487)***
3. BETH	*"...he developed a bit of an attachment to me, and although I explained that I was married, and you know, the sort of, roles that I have, the different role, how he can form a relationship with, how he can do that, and that sort of thing. He had, you know, he had considered that we can have a relationship, so I have explained very clearly, so this thing was very present, that I wasn't interested in a relationship with him, and why, and yes, this was too much for me, boundaries were shaken, and so, and this was, intruding"* ***(P23/L262-265)***
4. CARLA	*"Which as you can see, emm it is…yes very difficult for the therapist to find the right distance from these persons, not only for them but also for ourselves as therapists. It becomes, emm yes often becomes very difficult for me as the therapist to find the ways to come close, it's frightening, especially at the beginning"* ***(P6/L30-32)*** *"But I'm thinking of a patient now who, he is very young, 24 years, and yes, he is very attached to me, and he was like this from the beginning. In our relationship it is me who finds it difficult to contain,*

	hmm (P)…to contain his dependence on me. Sometimes is unbearable, I find myself wanting to stop the session. I don't obviously. But, yes, his needs to come closer to me, physically, symbolically, emotionally are too much" ***(P7/L36-38)*** *"With [redacted] I have to be very careful, with my responses. I have to, yes, be careful how much I give to him. Yesterday for example we had our session and, yeah, this is difficult for me talking about it now. No, not difficult because I don't want to tell you, for, you know any reason, but it feels difficult now thinking about him"* ***(P7/L40-42)*** *"To come close to me. I felt threatened. Yes, it was like that"* ***(P14/L89)*** *"But, see the patient was full on with his psychotic stories and I felt lost. I didn't know from where I could start. And then I shared my experience as openly and clearly as possible, and yes, I was transparent. But it was clear to me afterwards that something happened with my autonomy. See, my, my autonomy was shaken to say the least. Gosh, it was difficult. Very difficult"* ***(P16/L109-111)*** *"I mean, in this particular case, the patient was frightened to come closer to me emotionally but I was scared as well. And I am thinking, I mean I can think of many moments were I would approach him, and he would allow me access to his emotional world and it would become too much for me. And that's, I mean coming closer to him, meant that I was becoming closer to parts of myself that I didn't know existed to a certain, yes, to a certain extent"* ***(P18/L123-125)*** *"...yes, space to realise, sit with his autonomy. And mine of course (p) (laughing). See although, yes, I mean I find myself often thinking where is the patient, where is me, us in the room, yes it happens often, this in and out it's vital. Very vital, I mean if I don't pull back from the work, it feels like I am creating obstacles between us because I need my space"* ***(P22/L167-169)*** *"Sometimes he, he would come and say things like, "I wonder how would it be like if I saw you naked, and we had sex together" and then, yes, so, he wants to come closer, and then you see, this often the case. It's the boundaries again, and of course you have to be careful, but I don't want him closer, no I don't. And I would go into internal monologues, saying things emm…like "go away from me", my independence is shaken, and it becomes difficult to follow but, yes, with patience we go there, I mean, I deal with it. It is also a matter of autonomy, which is often sabotaged you know, I mean it's a common thing when working with psychosis, for me at least"* ***(P34/L273-275)***
5. GEORGE	*"When it becomes overwhelming for me, so I'm on a physical level a very freaky person. I'm very up-close with people, I'm very touchy. That doesn't bother me. It starts to bother me when I sense that there is a complete disillusion of boundaries, and when I actually start feeling that this is going a bit mad and when I actually start to experience a full sense of madness which I'm not comfortable with. And that usually feels, happens when I feel I have lost all differentiation and I no longer know where is me, where is them"****(P30/LP22-23)***
6. JOHN	*"So it's inevitable that (p) almost inevitable that the distortions will appear and manifest themselves in the intersubjective relationship with the therapist. As well as of course with family members and those distortions can be, can cause problems in their own right for myself as a therapist. It can be distressing, disturbing, confusing, painful, shameful, humiliating, intruding, so an essential capacity of the therapist is to do what they can to contain the impact of the distortions within themselves, manage them..."* ***(P7/L25-28)*** *"Because well as you know, well sometimes there can be great confusion or loss of boundaries as one of the common features in the more severe psychosis a lot of being unable to differentiate between self and other, (p) and to some extent one might sometimes find oneself doing things and only afterwards realize what was getting caught up into..."* ***(P14/L90-92)*** *"It was demanding work because at times it was very confusing, the voices were not quite easy to understand at times, and his change, his state, the voices would come and go a lot, sometimes they could be almost magically disappearing and then they came back again, like a chorus. So it was hard work, to my relationship with him"* ***(P21/L154-165)*** *"I mean I suppose a common thing is that we like to feel ourselves as helpful but you can get stuck and actually there is something you are overlooking, completely left out, in which the opposite is actually something hoping to be held in some way but it can be speakable about, and not think about it either. It's…it's too narcissistically wounding or something like that. And there, there is responsibility. Responsibility falls on me* ***(P27/L230-232)***

SUBTHEME 3.2: DISRUPTION OF REFLECTIVE CAPACITIES AND CONTRADICTIONS	
1. PAULA	*"She will often call people silly names. There are times when she would say, oh I have seen you earlier today, and I have already had a conversation with you. I spoke with the invisible you. Or there was a time when she called me the pixie lady for about a year. I guess, I think this is a very difficult case and sometimes it's almost impossible to reflect upon these things"* ***(P23/L118-120)*** *"I mean, I have a formulation, but there is too much there to make sense of. There is too much discontinuity and it's impossible to put the links back again and that she has a coherent sense of self or how I would like her to have"* ***(P27/L138-139)*** *"Well it's difficult really. I mean for the most part, I tend to think of my role in the NHS really and it can just be totally confusing. Exhausting. I recently receive more of psychodynamic supervision because I have been supervised for a long time from a CBT perspective and not from long-term psychotherapy approach supervision but that's their main approach and I've realised that this didn't allow me to reflect on this and other things [P]"****(P33/L161-163)***
2. BARBARA	*"I don't know what's the other one, I know, I can imagine there is emm…a more connected explanation, because this is again something, from, nothing connected so I don't, I, I, don't have an image for (p) you to form an understanding or to feel what's going on, except from the fact that there is nothing to hold on to"* ***(P67/L329-331)*** *"I think its unease. It's restless. It's irritating. Not in the sense of being angry at them, because sometimes I can't find the words for feelings, so it's not that, it's like an internal irritation, you know this is not right, it's something that it's not working"* ***(P76/L382-383)*** *"Emm…to do that, my part, I need to make connections. It's kind of, it's the beginning and not sometimes thinking that that's the work itself, it's just to make the connection and if that doesn't happen in three years and that's fine. It's not. I mean it is, also because sometimes it's just the way it is. And that's a struggle. Struggle to bring it, to talk about it. Not let it slight away. I don't know. There must be a feeling, which describes it. Do you know what that is"* ***(P78/L391-394)*** *"But I don't have a sense of…so, if I don't have a sense, I don't know, I also don't know myself in it. Because I don't have a sense, because I can't put it on her, I can't put it on me. I don't know. So I can't just describe openly what's happening"* ***(P81/L404-406)***
3. BETH	*"…and although I explained that I was married, and you know, the sort of, roles that I have, the different role, how he can form a relationship with, how he can do that, and that sort of thing. He had, you know, he had considered that we can have a relationship, so I have explained very clearly, so this thing was very present, that I wasn't interested in a relationship with him, and why, and yes, this was too much for me, boundaries were shaken..."* ***(P23/L262-265)*** *"This person needed something very specific, you know this is what you can do and this is what you can't do, so building boundaries so that he, he will know what's, right and what wasn't. Because it was very confusing as he had said"* ***(P24/L269-270)***
4. CARLA	*"We work together for almost two years now, no, that is wrong; I think a little bit more. Actually almost three years? You see what is happening here already, thinking about this patient makes me block, not thinking as I normally do"* ***(P8/L44-45)*** *"Well, spot on (laughing). I also said earlier on, you know, when I was thinking about how many years we are working together with this patient, and I gave a wrong answer, I mean, confusion, do you see what I mean? (p) So I guess it's also a matter of omnipotence and after so many years of experience I still, often, yes get caught up in it, and there is confusion, when coming closer to him I feel attacked symbolically, my thoughts, and it is very strong. I mean, it is many things together. So I kind of, find it difficult to think properly..."* ***(P21/L157-160)*** *"This is the beauty of working relationally. I mean it comes naturally to me, yes, and I don't find it difficult. I can think of difficult moments, yes, but generally speaking it is easy. I mean, I don't know, particularly, yes (P)"* ***(P20/L149-150)***

	"I have noticed that when I keep an emotional distance from him, he gradually becomes paranoid. I mean, it is very implicit, but it happened a lot of times. So it is the whole thing, yes, around I want you to come closer. Which is not difficult to me, but yes" ***(P20/L153-154)*** *"...you know sometimes it was very difficult to understand what he was saying, I couldn't follow his stories, and I couldn't connect with his emotions..."* ***(P33/L257-258)*** *"I mean, in this particular case, the patient was frightened to come closer to me emotionally but I was scared as well. And I am thinking, I mean I can think of many moments were I would approach him, and he would allow me access to his emotional world and it would become too much for me"* ***(P18/L123-124)***
5. GEORGE	*"For me, this might sound weird, personally it is not challenging but to get the team to join that world and engage with, it is very challenging due to the very fact that, from a phenomenological or intersubjective point of view one may conceive of as a subjective reality of any given patient..."* ***(P3/L35-36)*** *"But I personally don't find that difficult at all and it depends how concrete or metaphorical you take a narrative"* ***(P3/L44)*** *"So my experience is that I can completely make sense of the patient's experience, which is usually in psychosis characterized by threat of some kind"* ***(P5/L56-57)*** *"So if you truly allow yourself to immerse yourself into the narrative of someone with an inner psychotic episode, what you come out with is the experience of how they are relating to the world, or how they are situated in the world, how free or not free they feel there, and it's always internally coherent. I never actually worked with someone with a diagnosis of psychosis whose experience didn't have internal coherence. If that makes sense to you"* ***(P5/L64-66)*** *"But as a clinician and as a human being I find life maddening, it is manageable, but I can relate to the experience"* ***(P9/L130-131)*** *"Yes. Absolutely. If one I think is (p) I don't want this to come too self-indulgent, but if we are daring to be honest enough with ourselves, we can relate to most of these experiences if we allow ourselves to feel them"* ***(P16/L279-280)*** *"So yes, coming back to your question, I've never found anything really, not in psychosis anyway (laughing) that I can't relate to a patient"* ***(P16/L290)*** *"But with most psychotic people I can actually, I feel actually emotionally related. I can relate to the world being mad, I can relate..."* ***(P16/L298-299)*** *"And that is particularly easy with psychotic people because they can easily talk, talk, talk, talk and then you think where on earth is this going. Particularly if they are slightly thought disordered so they might be saying something like "so I was rushing and I saw a red bus and then oh my God, and then I thought it was Tuesday". This is a slightly thought disordered sentence which you can't quite make sense of..."* ***(P18, L318-320)*** *"It's a level of despair that I have never had that I can't, in some way it's not something that I can go in and say we can do something with it and it will be okay because I couldn't feel it in that moment that it would be okay. Does it make sense? So there is an example where I got the feeling where this is too horrific. Either I can sit with that or I can't actually say that I can relate to it because I couldn't. I think because it was too horrific or because I had no template within myself that allowed me to go there"* ***(P20/L362-365)*** *"When it becomes overwhelming for me, so I'm on a physical level a very freaky person. I'm very up-close with people, I'm very touchy. That doesn't bother me. It starts to bother me when I sense that there is a complete disillusion of boundaries, and when I actually start feeling that this is going a bit mad and when I actually start to experience a full sense of madness which I'm not comfortable with"* ***(P30/L551-553)*** *"Because you've dragged them out of this isolation, you showed them I can relate, and they might have confused this with a primary bond that they never had. And to then clawing it back and almost make the point that this is what happens with all patients, it's not unique to you..."* ***(P23/L432-433)*** *"So I can come here, enter this space and can relate for a moment, I open some experiences up, you listen, and we probably never talk after this again. And that's okay. And for me that is okay because I live life where I can get closer to people and I can have moments of connection and because I can have them I can let go of them, that is okay"* ***(P25/L449-451)*** *"Whilst again, with the patient with the tooth problems, if he was a private patient and if I was to get paid for it, I'd happily see him twice a week for the rest of my life. He fascinates me. He's funny when*

	he's okay, tremendously funny. Because he sees so many things in the world that other people don't see, more nuances that I find funny" ***(P25/L463-464)***
6. JOHN	*"Because well as you know, well sometimes there can be great confusion or loss of boundaries as one of the common features in the more severe psychosis a lot of being unable to differentiate between self and other, (p) and to some extent one might sometimes find oneself doing things and only afterwards realize what was getting caught up into..."* ***(P14/L90-92)***
SUBTHEME 3.3: ASSUMING RESPONSIBILITY	
1. PAULA	*"Erm I think it's been very difficult actually. It's being quite a long time now. Initially I would feel quite uncomfortable with that I think. And I'd find it much more difficult to be present and I would be probably more keen to reflect on my need to pull back from the work and [p] I would be questioning whether there is any value of me being there. I mean whether my presence increases distress rather than help and I'll be struggling with my confidence regarding the interventions"* ***(P24/L126-129)*** *"Yes. So I'll be wondering whether I should be working with this person. Or would it be a better place somewhere else"* ***(P25/L133)*** *"So, where is this going? And to control it in some way to keep this person safe and whether that's possible. Whether we can sort of, I guess something about things being manageable and not putting things in the way that might be unhelpful. I am feeling quite responsible for that really"* ***(P35/167-168)*** *"I guess those things cannot necessarily be fixed, acknowledging that. Erm... that actually you're to meet somebody's life in a very significant way that it's quite a big responsibility really. Especially when you might not be able to do much about it"* ***(P45/L209-210)***
2. BARBARA	*"A fault of mine. Sometimes I (p) don't see the other parts. Ok, so the client that I feel very connected with, there was a time when he was making another guy's life like hell, and he was very sadistic and very abusive, and I didn't meet that part. I can hear about it, so I also, for, when he would say something abusive to me, I would say ok, it comes because it's him, it's because he is paranoid now, angry because he is…whatever, and I…didn't stay with the front. Which is sometimes very very thick. So I think not staying with the front it's not just good. It's also a fault; it's also something, which is problematic. And I don't know exactly how to sit with that, but something that I have been thinking about, throughout my work with him"* ***(P64/L299-303)*** *"…the treatment because it doesn't give her anything, it has nothing to offer. Same time that I was thinking maybe I should talk to another therapist to do some work with her. I don't know"* ***(P71/L349-350)*** *"Well, it a frustrating, tiring, emm…hmm…(P). I guess it depends when…but failure; guilt also comes up…again some come or less. I don't know if there is a word for about…to feel unethical, like I am not doing my job. With the other client, the male client, we were working at six months and I think I slowly manage to close the gap, but to feel that gap, that I don't like him and he likes me. It's kind of…of…like I don't know; it's a feeling by itself. To fill that gap"* ***(P75/L378-380)*** *"Well, when talking specifically about the gap, or not just the gap, maybe, but it's like I am deceiving somebody. It's a very, it can be a very intimate space. Like if I don't, can't, to be there, if I want to be there it's I guess possibly something that I could handle better than if I just don't…want to be there"* ***(P78/L387-388)*** *"Yeah, yeah. Alone, lost, unclear. It's not even, it's not even, I was kind of thinking failure. But it's not even that. It's before that. It's not even failing to do something. Hmm…Yeah and then (p) in a sense it's difficult ethically, because we are suppose to do something. This is the occupation of change. Profession of something…of substance"* ***(P72/L359-361)*** *"And I felt that I might be doing something really really wrong, like I am caught in some sort of...something I cannot see"* ***(P34/L143-144)***
3. BETH	*"…so I kind of totally disconnected from him and I, I think it was quite obvious actually, but I don't think I lost him, as such, I think it was, it was totally my issue"* ***(P26/L302-303)***

	"So I had supervision and I spoke to colleagues, so it took about a week for me to kind of calm down and return to him and I think it was completely my issue to carry on pretty much from where we were and see whether he wanted to do therapy, what he wanted to work on end, yes" ***(P27/L310-312)*** *"I thought it was my fault, but it wasn't, but I kind of thought that I could do this and that, it was part of my, I can save him, I'm afraid I did have a bit of that, even though I tried to leave it aside. Most of his weight fell on me and I, well I probably, better I took his weight, because I wanted to. It came; I also took it, because nobody told me that I have to see him four times a week. I thought I would be able to help him, but on occasion I would feel angry, oh for goodness sake, we did work four times a week, or sometimes even twice a day and we talked about this several times"* ***(P34/L352-356)***
4. CARLA	*"Yes, wondering about the boundaries and about me being a bad therapist for him"* ***(P10/62-63)*** *"So yes, it was so strong, and then when he, when he (P) when he came for the next session I was very passive, I didn't allow him to...well…it was strange, I felt guarded. And it felt like it was totally my own fault of what happened, I mean this whole disruption between us"* ***(P13/L86-87)*** *"Oh, it was horrible. I felt very upset, and angry with myself, guilty. That it was my entire fault. And then I tried to invite him to explore what has happened between the two of us. And the difficult part for me, very difficult part was to sit down with my vulnerability in the room, I felt naked in a way. And you know, it was a mistake of mine, I shouldn't have touched him that day"* ***(P15/L98-100)*** *"You know it is very easy for the therapist to say that, you know, you know, the patient is not responding enough, or the therapy isn't going well because it is the patient's issues. I mean, in this particular case, the patient was frightened to come closer to me emotionally but I was scared as well. And I am thinking, I mean I can think of many moments were I would approach him, and he would allow me access to his emotional world and it would become too much for me"* ***(P18/L122-124)*** *"I have noticed that when I keep an emotional distance from him, he gradually becomes paranoid. I mean, it is very implicit, but it happened a lot of times. So it is the whole thing, yes, around I want you to come closer"* ***(P20/L153-154)*** *"And you know, all these obstacles I was putting between us, because, I, I, you know sometimes it was very difficult to understand what he was saying, I couldn't follow his stories, and I couldn't connect with his emotions, but it was also my issues there. All the paranoia, the hallucinations in the room, was he, he was creating another persona in the room, one that he preferred compared to the actual person, me, I mean"* ***(P33/L257-259)***
5. JOHN	*"I am always asking myself, where has it gone wrong? Or have I missed something, is it me or is it the patient, where is it, where is it, is it possible to locate some issues more in me, more in the patient, or somewhere between us. Or what's the consequence of me having not done this, or said this, on, on, the relationship between us"* ***(P26/L218-220)*** *"...a common thing is that we like to feel ourselves as helpful but you can get stuck and actually there is something you are overlooking, completely left out, in which the opposite is actually something hoping to be held in some way but it can be speakable about, and not think about it either. It's…it's too narcissistically wounding or something like that. And there, there is responsibility. Responsibility falls on me* ***(P27/230-232)***
SUBTHEME 3.4: <u>COMPENSATORY MECHANISMS</u>	
1. PAULA	*"I guess it makes me think about that kind of attaching and moving away to a degree. I think there is a way in which I support that in terms of how I ground people and at the end of sessions and focusing on something that is reality based and more real. But I am detaching a bit in that, in sort of ending the encounter"* ***(P51/L250-252)*** *"...sometimes when I start looking for tools and they might inevitably be CBT related tools, because CBT has a lot of tools, more of the doing interventions I wonder if that relates to a, I guess it's another*

	way for me to sort of structure myself and make sense of what's happening but also possibly sometimes another detachment from the being-with" ***(P61/286-288)*** *"I guess, I think this is a very difficult case and sometimes it's almost impossible to reflect upon these things. I think there is a fine line for this particular lady between personality difficulties and psychosis. And, there are times when there is clear psychosis and other times a borderline personality disorder element in terms of her seeking care"* ***(P23/L119-121)*** *"Because you see, what was difficult for me was needing to have an intervention really needing to do something in our meeting so that it would be valuable for the NHS. So working with evidence in a way, and having confidence about that. So there is a need to force something, to do, do to her, to feel that therapy is more constructive. And doing the sense making when she is allowing the sense making really"* ***(P31/L154-156)*** *"We have a lot of skills of just being present for clients that I think enable you to sustain a relationship when it's very difficult. So I've always felt like that, and yeah but I don't see many counselling psychologists do what I do"* ***(P6/L17-18)*** *"I am able to offer them a different type of relationship and I see that as having some value really. Its often not about recovery or change in the same way as I see it with other client groups. Sometime is about being there for the client being able to offer a different sort of relationship that they can learn from"* ***(P13/L58-60)*** *"I am talking about the team generally but she is better able to engage with me"* ***(P21/L106)*** *"She is very dissociative and the rest of the team would see her as playing games, as being a child"* ***(P20/L103-104)*** *"...but you often go back to an environment that it hasn't got much of a capacity to see life on a continuum and acknowledge our own madness"* ***(P45/L212)*** *"So I'll be quickly faced with a lot of judgements and appraisals about…someone being controlling, playing games, a lot, and a huge level of anxiety and chaos around whether this person has a psychosis or not. There are times when it is clear that there is psychosis but other times there appears to me that something else is happening. And a certain expectation about what a team should be able to achieve. And how things are making sense. I think I take this as part of my job really. How they are making sense of that and sort of being able to make sense about the team dynamics as well. But sometimes coming to a busy day to see a client that is that complex you are already not really present to yourself. And that has a direct influence on the work really. You can find yourself being pulled into other people's attitudes and ideas about what's happening. The third person being in the room in a way, the psychiatrist, the nurse, the social worker etc"* ***(P47/L223-229)*** *"Well I am at a setting where is primarily nurse laid; psychiatric nurses and they have a certain attitude, which is very pragmatic. Focused upon you know, skills, solutions, fixing things, and that's very strong. Often there is a sort of gaze on you, what are you doing, what are you contributing to working with this client or there is a perception that If I was to talk about being with somebody I get laughed at the team at times. And it's quite hard to fight for that. I think alongside pressures, lack of recourses and pushing towards certain pathways and the pressure when there is no improvement from these clients..."* ***(P49/L240-244)***
2. BARBARA	*"We have group supervision, and I brought somebody that I don't feel connected with…emm..I'm not sure…when I talk to him or when I talk about him I feel closer to him but when I see him at the unit I don't feel like going and say hello. I don't have much connection. And he says, he says that sessions are helpful and meaningful and so we kind of breached this gap that I am not comfortable with. And I was emm…I brought him to group supervision…and I think… I'm not sure if he was fully behind what he was saying…and my…why why do you, this thing that you are supposed to love your clients. Why? Who said it? Could it be someone that you just like, that you are close to"* ***(P58/L275-279)*** *"And I have another one that I am only working for…it's more on the ADHD, borderline area, but we are only working for a month and a half, he is going to be leaving now he will not stay, anyway, very difficult to connect with…"* ***(P66/L314-315)*** *"And she was diagnosed at our unit with paranoid schizophrenia and the other girl is like hardcore borderline and something in that mixture, kind of went through…a layer and it wasn't working. Too many issues yes, borderline and psychosis made the relationship difficult"* ***(P81/L418-420)*** *"But sometimes, when the connectivity is not as strong, like I had a client, I worked with for 7 months and then left and emm…and I just started…it wasn't…and they were talking about being borderline…false self. Everybody failed her false self. And at the beginning I didn't, and I was thinking, ok, maybe I don't see it because they are here for a long time and they are all talking about it, as being part of, specific borderline, that she is and everyone was talking about how she's bringing up*

	her false self and I started to see it in sessions and I think that was wrong. I was influenced by that and I wasn't aware yet…that I could have been very different, a very different space. So sometimes, something different happens and I think it's contaminated our space" ***(P97/L505-510)*** *"So, I have these two schizophrenics that I find difficult to work with, their schizophrenia is very strong and it makes it difficult"****(P97/L512-513)*** *"Ok, how come that I feel something else? Something nobody else feels. And what do I do with it? How do I mediate it to the staff? Do I need to mediate it to the staff? So I kind of fill the gap"* ***(P97/L504-505)*** *"This was very challenging. And then the other one was that I've heard from the outside a lot of criticism, talking about how poisonous he is, and destructive, and sadistic, and I couldn't feel it"* ***(P34/L140-141)*** *"I think I abandoned…emm…when not connected, emm...I had a session with a client, she's borderline…emm…either borderline with psychotic…emm…(p)"* ***(P45/201-202)***
3. BETH	***"****Working with people with psychosis interrelationally which I don't think is something that happens that often. In my experience anyway"* ***(P2/L5)*** *"So, the role of the psychologist there is very, very big"* ***(P12/L96)*** *"Emm...and one of the things that came up, I think it came out of our work and not the work of anybody else, was that he was able to form bonds with people, and emm..."* ***(P16/L135-136)*** *"...who I had problems connecting with has a diagnosis of bipolar disorder, slash psychosis. Emm…so this particular person, he was also in the group, I worked a lot with him. We started, I'll just explain that initially, the point was to get him to understand the psychiatrist thought would be helpful, to help him to understand what his symptoms were, why he had this diagnosis he had, so he'll be able to manage it. Because he is actually a quite functional person. Emm…very, very functional. So, emm…he had a lot of difficulties with people he lived with, the less functional. He had issues with superiority and inferiority, that sort of thing. Narcissistic type difficulties"* ***(P23/L210-214)***
4. CARLA	*"So yes, it is difficult work, but, yes very difficult at times but very rewarding. And very few of us do this work"* ***(P36/L294-295)*** *"But the other co-workers, are not always ready, I mean I don't blame them. They are not always ready to understand what's going on with, emm…they sometimes raise obstacles, their thinking it's not sensitive to the therapeutic process. And yes, sometimes it is a real problem, it becomes a real problem because nurses, and other psychologists even or psychiatrist are not trusting the work and they force me to show results"* ***(P35/L285-287)*** *"But one has, this is a rule for me, yes, emm find people who can trust and speak about clients, supervision is very important, yes. But again it's very difficult, very few of us work intersubjectively"* ***(P35/L289-290)***
5. GEORGE	*"For me, this might sound weird, personally it is not challenging but to get the team to join that world and engage with, it is very challenging due to the very fact that, from a phenomenological or intersubjective point of view one may conceive of as a subjective reality of any given patient, that subjective reality is usually defined by what the psychiatrist or the nurse may think and constitutes the person as been mad, so to ask someone to join the subjective world you are literally asking people to confront something that they consider as madness"* ***(P3/L35-38)*** *"Most people I do think have neurotic defences, which protect them from truly engaging with the reality that nothing is quite real and that life is quite mad if we truly, truly look at it. And few people have the capacity for that"* ***(P6/L82-84)*** *"...and I have worked at an interpersonal level with them that other people would have been mortified by..."* ***(P9/L128-129)*** *"Now if I was a classic NHS person, I will think alarm, alarm, alarm you need to get into the hospital. Danger, danger, danger. But because I am not..."* ***(P9/L128-129)*** ***"****Because I have taken tremendous effort, if I can use the terminology, break into their world, and most, a lot of people would not make this effort to break into their world because either they don't care or they are terrified"* ***(P25/L455-457)***

6. JOHN	*"So you can think of a bipolar, a person, what's called a bipolar psychosis, they can switch from being wonderful, euphoric affect emm…and idealizing you and all kinds of things and issues"* ***(P10/L51-53)*** *"I think he realized that what we, me and my colleague were offering him was something different from what he'd experienced before"* ***(P21/L145-146)*** *"…so I think the fact that he (p) rather than other approaches which were trying to sort of get rid off the voices and things like that and so on and suppress them and so on..."* ***(P21/L147-148)***

MAJOR THEME 4: THE LIVED EXPERIENCE OF BEING-WITH

SUBTHEME 4.1: RELATEDNESS AND CONNECTIVITY

1. PAULA	*"You know thinking about it I have a great influence over, but often is also erm [p] sometimes with humour, or sometimes it can actually come out of the discussions with them, it comes out of the more human relationship, rather than me trying to employ a diary for them if I am using a CBT intervention. And I guess that brings me back to the difference between being and doing and being aware of that. And being-with allows forming the relationship but with this client group that comes with its challenges because often many difficulties arise in the relationship"* ***(P39/L185-189)*** *"R40: And how would you describe yourself in a being-with mode with a client? P40: I guess I am more present emotionally in terms of acknowledging the whole person, not just the psychosis so we might not be talking about that. With that I am more present within myself, I bring more of myself to that"* ***(P40/L191-192)*** *"But I actually very quickly formed a relationship with him..."* ***(P17/L80-81)*** *"...but he was able to form an attachment and to start to trust me and start working on all of those things"* ***(P17/L84)*** *"And I suppose I sometimes see working in that context, within that team I am constantly involved in some way, I am still present for some of the clients within my team where I am not necessarily seeing them for weekly therapy sessions or I am still holding them in mind"* ***(P17/L90-92)*** *"I guess there are moments of reflection and challenge and quite recently I had a quite significant reflection with somebody about them acknowledging how they had a fantasy that I could look after him"* ***(P56/L264-265)***
2. BARBARA	*"It happens naturally and today you know when we were going towards the end of therapy he knows exactly how I feel towards him. He knows the difficult times; he knows things that now we can talk about it freely and about the connection between us and that's because it was there all along. You know it didn't just happen"* ***(P32/L128-130)*** *"It becomes difficult when they don't enter your heart, sort of becoming a significant other for the treatment, becoming something that I can...that I want to work with, feel connected with"* ***(P36/L151-152)*** *"You know, to see the potential I think that's what connects me to clients, some kind of potential that you can connect with them, have a bigger space in them. Emm...to want to work with them also...to want to explore them, to be interested and really curious about them. Emm...it doesn't always happen. Emm...no that's not true. You can find it if you look good, that's the thing, but sometimes you need to look hard. Like, there will be some clients that I connect with them really quickly"* ***(P37/L159-161)*** *"I think when I know that is that, is when I become jealous of the guys that spent with them 24 hours"* ***(P39/L167)***

	"Well, I think I get something from it also. They become meaningful, for this connectivity they become significant. So it's a good place" ***(P55/L269)*** *"...when I feel some sort of connection, these are the places where there is the…will…and where there is will there is a way. And hopefully, if the will exists from both sides then we start working"* ***(P60/L288-289)*** *"I think there is connectivity; we have a very strong relationship. I am not underestimating that relationship. Emm…or we can look at and…but there is this lacuna, this area that we don't enter. And that possibly is you know, a deeper level of connectivity. It's not that it doesn't exist. It's not that there is nothing to hold on to"* ***(P82/L424-426)*** *"...and I think if I would think hard I can find the places where he was there for me. But I think that's very important"* ***(P54/L259-260)*** *"And with her is for both of us, we both kind of, there's this area that we both don't enter. So it's not just her that doesn't enter. I don't enter there, and it kinds of stays…emm (p) We have another six months, so we have started talking about it now. On the last session, the last last session, it was really, almost kind of talking about that, you know, talking about us, what's missing, what's not there. It's always, always spoken of…not…kind of rushed upon it and I think that's something that (p) and I think that on her part emm…it has to do with her breakdown that causes, you know, a deeper fear of attachment etc etc etc. And with me it's more neurotic. But it's there. And I am not sure, I think what we can do it together, is possibly highlighted…we…I think we'll be able to pass through it because, because it's somewhere that we need, so that we can get connected with this lack"* ***(P81/L409-414)*** *"To…you know to, to get to know them outside…well not just. To get to know them outside the therapy room and I imagine to get them to know me in different set"* ***(P42/L184-185)*** *"...I do think that there is something about becoming a solid object for him but for me was also connected towards the relational approach. I really see the connection there. And for him to really know what I feel towards him, to be aware of what I think about him and how I am with him. The fact that...emm...be embarrassed at times, make mistakes and listen to him, take him seriously, was a lot of the work. That there is somebody that I see and that he sees himself through me. So this openness it needs to be there in order for them to have it"* ***(P53/L246-249)*** *"I mean, it is the connection**,** it is the…and the…the…I think is the right word to describe the relationship. So I think it's good. And then, once is there, then (p) so I am thinking…so I have this client that I am very connected to, 2.5 years we are working together, a long time, he knows me, I know him, we can work in a way that is suitable for him…"* ***(P66/L312-314)***
3. BETH	*"Therapeutically I connected with him, straightaway especially when he first started... So he was someone who opened up straight away which I liked, extremely honest about what he thought"* ***(P26/300-304)*** *"But we had a lot of moments where I felt that we were connecting if you want to call an I-Thou relationship. The, I don't know if I can describe it completely. I know that I feel very close to someone else connected when I feel emotional I got tears in my eyes and (p) when time flies and I don't realise..."* ***(P30/L322-324)*** *"...when he was connected with the sadness and he had tears in his eyes, I found that, I would be able to be connected with him, there. I knew physically, more physically I will go with that, whether it was true, true emotion, or whether he was trying to bring an emotion in me, as in to use me, which he very rarely did. When he, when* [redacted] *was connected to his emotion, for me it was totally real. Actually, talking about him I have a physical reaction, my stomach is hurting. And I'm imagining that probably at the time of, having that physical reaction, I certainly would have tears in my eyes, and yes, and normally when I feel emotional I also have pain in my stomach"* ***(P33/L339-343)*** *"A lot of sadness it was very overwhelming, he was somebody I got very attached with, and it was very sad when he left"* ***(P34/L352)*** *"Sorry perhaps I'm going too much into it. But I was extremely connected to him and by using myself I think slightly too much I became I sort of followed the vulnerable child a bit too much, and he was actually very helpful, he kind of realised that not in these exact words we were able to sort of organise that together. So he would, yes. Anyway I don't want to go too much into it. He helped me and I helped him. That's what I want to say and that's what I think it's very helpful when you're more present, you need to be very careful when you are present, because you can get a bit confused and that's where the intersubjective bit comes in..."* ***(P40/L428-432)*** *"...so because I am doing a lot of art therapy, they talk a lot about the space between, between you and your artwork, with is the space between you and yourself or you and the other person, and the energy*

	that is created between you and, so if I were to think about it in those words, yes if someone was more vulnerable I would feel that I will need to be closer to them, be more intact..." ***(P46/L472-474)*** *"I just find it extremely interesting, and I'm more in love with it than scared by it. I feed my anxiety, I use anxiety quite a lot, so I am someone who gets quite stressed, I feel I can connect with people with psychosis by no means have their experiences, so I don't hear voices or have unusual experiences, but I have on occasions and I think most of us have, quite paranoid and extremely anxious, but much more than I need to"* ***(P49/L487-490)*** *"I felt very alive, I, I was happy that it seemed helpful for him, I was sad that I didn't catch my countertransference in time and I went into too much, I was too connected to him..."* ***(P41/L435-436)***
4. CARLA	*"But, see, there was another part of me that, that felt so strong, see I had the need to go and care for him, and tell him something. And I did. My human side was activated; let's say I deliberately decided to come out of my therapist role. And, yes, there, I, I said something comforting, and I put my hand on his shoulder and I will never forget how he looked at me. It was, I actually feel it in my stomach now, it was, it's like (P). So, I felt that we were one at that moment. But you see, it wasn't, I didn't feel that there was no boundary there, there was, but we were one and two at the same time"* ***(P13/L81-84)*** *"He is such a wonderful man, so clever, and, and, yes, so interesting. I often look forward for our session, it is so easy now to follow him, emm and also, he knows that, he feels that, yes, he tells me that sometimes. I get so many things as well, from him (p) he seems to, he holds for me, and not only him, he holds parts of me, if you prefer, contains some of the craziness that you don't get with other patients, I mean the more neurotic, so it is a very rewarding relationship. When, emm…you asked about the connection, and, emm…yes, it is a very strong connection, I feel for him, emm…I mean I care for him a lot, we have a space, we created a space, which is very safe for both of us, I hope (laughing)"* ***(P34/L266-270)*** *"See, this patient was able from the very beginning to stir, yes to mix very different emotions in me. I would become very, very emotional in the sessions, or very angry, or very anxious, and I'm not sure how this sounds, but our relationship is able to contain me. Not only me, both of us, but I am talking about me here so, yes"* ***(P9/L53-55)*** *"Do you know any person that comes to our services to provide containing? They come, all people come to me, to us, because they need to be helped, contained, nurtured, and million other things but this is my role and yes, surely not their role. So I did find myself wondering (P). Yes, wondering about the boundaries and about me being a bad therapist for him. How can a disturbed person, and sorry, I am saying disturbed only because I can also speak of my own disturbances, yes…I mean it is not label or, you know, we all are to different degrees. So how can disturbed people hold me emotionally? There is something real and symbolic in this of course, as you understand"* ***(P10/L61-65)***
5. GEORGE	*"It has an affect on me. As I said with this patient he's someone that on a relational level I don't mind spending time with, he fascinates me. We had a connection, well, (P). Hold on, I don't want to be in assumptions. So there is people I meet in my life, friends, colleagues, something or other, whereby when you are together with them they see something and you can see it at the same time and it's a very beautiful experience because you share some overlap in your mind. And I am someone who loves that. I value these things in my life. Often working with psychotic patients, they can open up a world for me, which I often find fascinating and I can see it with them, and yes, I lose that. And I do find that very, very sad. So it is not just them, there is certainly a part of me that does find that sad but unfortunately is part of the profession"* ***(P26/L489-494)*** *"So that leaves me deeply sad as much as, you know often when you discover the world that these people have grown in, they are so lonely, so desolate, that it is actually truly upsetting; if you truly connect. If you manage to get into their world. If you manage to have a transpersonal moment with them and you can see what life looks like from where they are sitting, that can be quite sad and it's of course, well of course for me, a therapist, whilst we know that we cannot truly change another person, we nonetheless, I think we retain, some omnipotent fantasy that we can do something in terms of helping them. Because otherwise there wouldn't be any point of doing what we are doing"* ***(P25/L458-462)*** *"Whilst again, with the patient with the tooth problems, if he was a private patient and if I was to get paid for it, I'd happily see him twice a week for the rest of my life. He fascinates me. He's funny when he's okay, tremendously funny. Because he sees so many things in the world that other people don't see, more nuances that I find funny"* ***(P25/L463-465)*** *"And I feel the same with psychotic people. That I have access to an experiential world, which doesn't feature in my day-to-day reality and is a world I actually take pleasure in. Because I can find joy in madness. I can find it quite enjoyable. But that gets lost. And then there is a human element, whereby I know that, I often wonder how these people are and part of that wondering is much about me it's not just about them. So yes, it does affect me personally. But then, I assume that, this is a risk factor in working intersubjectively. If you allow yourself to relate to human rather than to pathology this, it's a relationship at the end of the day. A relationship, an encounter. Just because we call it therapy it*

	doesn't make it less human in that sense" ***(P26/L499-504)*** *"…as much as I contain sanity for that patient that they can't hold, they could hold my madness because that's their base position. It's almost like, it's a projective identification in that sense. It's something that I lose, and afterwards I have to hold it by myself again in a less productive way. And that's what gets lost in a very simple way for me"* ***(P27/L506-508)*** *"I find these people much more real and they contain a part of me that these people cannot contain. And there is the sadness. I feel left afterwards, I feel lost with that. Because I certainly think as I said earlier on, the world is mad. The experience of life is mad"* ***(P28/L512-514)*** *"…but be able to say that of course life it's maddening at times, that feeling is reality, where if I was to tell this to my colleagues in a peer supervision group in the NHS, they would have said, hold on you are making this worse. But as a clinician and as a human being I find life maddening, it is manageable, but I can relate to the experience"* ***(P9/L129-131)***
6. JOHN	*"A Greek patient actually who actually meant a lot, one day I went for a walk with him for a session, and I can't remember the circumstances that provoked that but just seemed the right thing to do..."* ***(P13/L83-84)*** *"It was demanding work because at times it was very confusing, the voices were not quite easy to understand at times, and his change, his state, the voices would come and go a lot, sometimes they could be almost magically disappearing and then they came back again, like a chorus. So it was hard work, to my relationship with him. I mean, I think I carried with me, into my work, a sort of quite confidence that I can be of help to people which doesn't mean to say that at times I have to be, feel, manage feelings…quite helpless at the same time, I mean there are setbacks and so on. Emm…(p). I was…I don't know if that's part of the questioning but its'…anyway let me say it. I was sad when we came to an end. I was (p) it was circumstances beyond my control or the services', so its boundaries and things like that but it meant that we had to draw an end, and I knew we had a lot more we could do, so I had to manage my own sadness and disappointment about the limits of what we had achieved, but the same time help him manage the ending too, and his family, because we were working with his wife as well, and I remember him saying at the end, "the voice will miss you" he said (laughing). That was quite touching in a way"* ***(P21/L154-162)*** *"...sometimes a spontaneous gesture in which one does something outside of the norm that can be helpful. I don't do this in a planned way, but I can remember working with an asylum seeker patient with psychosis who had, who was very on the edge…emm…and I think she was pregnant at the time and suddenly there was a crisis and she had to move at the weekend, and having got any sort of facilities and no money and things like that and I found myself with the care coordinator actually physically helping her move some heavy, you know washing machine you know things like that from one thing to another, and that meant a lot to her that I was prepared to do that"* ***(P12/L76-81)***
SUBTHEME 4.2: <u>THERAPIST'S SELF-EXPERIENCE</u>	
1. PAULA	*"I guess it comes up with just the acceptance of things. Much more existential level really. You know really difficult things happen in life and I suppose with that probably my awareness that difficult things happen in my life as well and how do I deal with that. And about being more grounded in that and I think the warmth is also from the position of the awareness of myself and from my own experiences of [P] if that makes sense really"* ***(P43/L203-205)*** *"I guess I am more present emotionally in terms of acknowledging the whole person, not just the psychosis so we might not be talking about that. With that I am more present within myself, I bring more of myself to that"* ***(P40/L191-192)*** *"And in the rest of my working life I am not religious as a person necessarily, or these huge amounts of customs and actually as a person I sort of resist to that but in my client work I accept it and see that it has value for people but it forces me really to question my own beliefs. If I'm truly present with someone it challenges me"* ***(P45/L214-216)***
2. BARBARA	*"I think I bring more and more of myself into the therapy room. I think that sort of wish was sort of stronger when I started working at the unit so the gap is kind of emm…but I'll say that emm…(p) I guess the more vulnerable parts. It's about getting in touch with your deeper self"* ***(P43/L189-191)*** *"Like a simpler aspect would be my issues. So why I went to become a psychologist, that my, my*

	struggles in psychology, my struggle is to make the connection. So this is…but I think it's also a meeting between us. Because there are other times which it doesn't happen. It's a space between each other on that aspect. (P) And I guess it is, it's like an echo of being rejected, or hurt, and being tempted to do something that doesn't fulfill itself. It's that, that area. That's the place that I can possibly connect with" ***(P84/L430-433)*** *"Sometimes when the connection is strong, like with the guy that I work for long term, then I kind of find myself within this gap. Like, being also aware of my own stuff."* ***(P97/L504)***
3. BETH	*"...what I remember for sure was that I had physical reactions, as in my stomach would hurt, or my eyes will be burning or teary, when I felt that he had understood something or had become closer or he had come to an understanding for something about himself, and that had mainly to do with his relationship with others. And the way he saw others in the way he saw himself so I am sorry I don't actually remember particular examples. But yes, very connected with, realities, parts of myself as well"* ***(P30/L326-329)*** *"So I actually liked that, I liked that I was connected, for them and also for me, for me, as a person, I had difficulty my life, I wasn't connected with my emotions and I didn't learn to do it, I avoided them for a long time so it is something that I learned and I liked, you know I did a lot of gestalt work, and person centred work and that sort of thing and I, so I would find it, yeah, I'll be pleased let's say. Not pleased with myself that I was doing good work but that it was something that it was a real relationship let's say"* ***(P33/L343-346)*** *"...but when I did feel something the emotion was too, and I would feel overwhelmed because what he was mentioning was real, like he would say I have no future, and I can't make any plans, and you know I…"* ***(P33/L349-350)*** *"The reason I mention this it's because I think it's quite important, I feel I can relate to these people. To some extent. And I feel very, so I connect with myself, with what I am and also I find it intellectually quite interesting. But more on an experiential level"* ***(P49/L494-496)***
4. CARLA	*"I really felt his pain, and mine. I was going through a very stressful period on a personal level at the time"* ***(P13/L84-85)*** *"You know, I felt that I suddenly became something I wasn't aware of before, like I, I, but that I also wasn't aware of. Something that terrified me. Yes, I did feel terrified. Also, because, you know, because of the experience of not knowing who I was in that moment, but also because of coming closer to a part of myself which was scary. And it belonged to me; it wasn't the patient's stuff. So at the same time I felt like a detached observer of myself and, and what was interesting was that what brought me back to reality let's say was the patient himself. I remember at one point looking at him and his gaze woke me up. I suddenly, very suddenly, yes, felt that experience of when I touched him that day that we were one and two at the same time"* ***(P16/L105-109)*** *"Well, protect me from having to face the reality that this patient was not very different, yes different from me in some way. In many ways actually. I identified with some of his difficulties. And I became detached in some way for some sessions. And I was losing him, and he was losing me. But we both tried hard you see. We were both part of this, and it was difficult for both of us. I actually think that it was more difficult for myself for a while"* ***(P17/L114-116)*** *"And I am thinking, I mean I can think of many moments were I would approach him, and he would allow me access to his emotional world and it would become too much for me. And that's, I mean coming closer to him, meant that I was becoming closer to parts of myself that I didn't know existed to a certain, yes, to a certain extent. What comes to mind now is issues around identity and sense of self. This patient's unstable sense of self threatened me but not only, I mean (p), it also enlightened something, to a certain extent, very existential about my sense of self in many ways. I mean my identities or roles let's say, as a therapist, as a mother, as a daughter etc and how they are connected or not"* ***(P18/L123-128)*** *"I can remember many times with this patient that when I have the need to pull back from the work, I, kind of, yes, sort of finding in me spaces that are mine, completely mine and I detach from the client because I detach from something horrific I encountered within myself. In and out, in and out all the time (laughing)"* ***(P21/L162-164)***
5. GEORGE	*"…things got under my skin where I couldn't step out of because I encountered a level of terror, that I had, or despair, that I had previously not found in myself. So either I took on the person's despair or because I allowed myself to connect, I found a level of despair in myself that I previously not been aware of. And it was scary. That sometimes happens. But that I can only call it the very depths of despair. Where everything is lost for example and one has a snapshot moment whereby you realize you can't hang on to anything in life truly"* ***(P20/L353-356)***

6. JOHN	*"In summary I see everybody having varying degrees of vulnerability and facing life, facing life issues and we all have ways of circumventing, we all get tripped up when too much are happening..."* ***(P8/L35-36)*** *"...we all have borderline moments and we try to blur the boundary between us, or locate something outside of our self which really belongs inside and so on, and try to stir people up to take it on board when we don't want to do it ourselves"* ***(P26/L224-226)*** *"...something overlapping from the patient that is touching something in me. So, that we've got some issue in common here. Oh…yes…oh…yes, yes. I mean I suppose a common thing is that we like to feel ourselves as helpful but you can get stuck and actually there is something you are overlooking, completely left out, in which the opposite is actually something hoping to be held in some way but it can be speakable about, and not think about it either. It's…it's too narcissistically wounding or something like that. And there, there is responsibility. Responsibility falls on me"* ***(P27/L229-232)***
SUBTHEME 4.3: OSCILLATIONS BETWEEN DISTANCE AND PROXIMITY	
1. PAULA	*"...and I think sometimes when I start looking for tools and they might inevitably be CBT related tools, because CBT has a lot of tools, more of the doing interventions I wonder if that relates to a, I guess it's another way for me to sort of structure myself and make sense of what's happening but also possibly sometimes another detachment from the being-with. And I guess that's quite interesting if we are reflecting on it in that way. Often it seems very natural and perhaps it's a useful thing to do and bring some of that to my work. But I think it's also helpful to reflect on it really"* ***(P61/L286-290)*** *"They also help me to keep being there. And I was thinking it in with regards to their own defences. They need their defences and I need mine. And sometimes this enable me to, helps me to understand something to make sense of what my role is, in being in the room with them. And it allows me to think of formulation when it comes to this client group because I don't think I could confidently say that my clients that present with a sort of residual psychosis that I have a formulation about and understanding that I am 100% right. I think sometimes these tools, these formulations help me to be able to make sense of the case and to take some meaning from it all. And to sort of be there and have some kind of relationship"* ***(P63/L295-299)***
2. BARBARA	*"The client I am working with now and his family which is about to end where he announced it and have found an apartment and go on and live his life and he for a long...emm...there was no, we could have, emm...we started with a lot of mistrust and then he settled well into my world, you know I liked him, he has good aspects but he can throw me out at any time. But the same can happen with me. In and out, but see it's part of the process, the relationship"* ***(P27/L106-109)***
3. BETH	*"And, the main work I did was reflecting and bringing myself fully into what was happening. He would be like "oh so you're thinking this, and you must be thinking that" so very paranoid, a lot of paranoid thoughts. And I would go back, and sit with myself, and I need my space to think and understand"* ***(P39/L395-397)***
4. CARLA	*"I really felt his pain, and mine. I was going through a very stressful period on a personal level at the time. So he didn't say anything, and I didn't, I just left and when I entered my office I felt so ashamed I did that. My superego forces we activated, so extremely I couldn't breathe for a while. So yes, it was so strong, and then when he, when he (P) when he came for the next session I was very passive, I didn't allow him to..well…it was strange, I felt guarded. And it felt like it was totally my own fault of what happened, I mean this whole disruption between us"* ***(P13/L84-87)*** *"So, but also because before I was talking about how important it is to find the good balance between distance and proximity, generally with all kind of, you know clients but in psychosis it becomes very important, more important. Yes, so part of this distance, which is very important as well because the client also needs help to understand that is separated from you But no, not just the client, me as well. If*

	I don't move back it feels like I'll get swallowed" ***(P19/L136-138)*** *"I can remember many times with this patient that when I have the need to pull back from the work, I, kind of, yes, sort of finding in me spaces that are mine, completely mine and I detach from the client because I detach from something horrific I encountered within myself. In and out, in and out all the time (laughing)"* ***(P21/L162-164)***
5. GEORGE	*"And to then clawing it back and almost make the point that this is what happens with all patients, it's not unique to you, this is just the work"* ***(P23/L433-434)*** *"So I can come here, enter this space and can relate for a moment, I open some experiences up, you listen, and we probably never talk after this again. And that's okay. And for me that is okay because I live life where I can get closer to people and I can have moments of connection and because I can have them I can let go of them, that is okay"* ***(P25/L449-451)*** *"So how close I can come, or how far away I need to be is exactly what I need to work with. Because again there again, in an existential sense all I'm trying to do with a psychotic patient is to drag them out of isolation. And in order to drag them out of isolation I need to find the right distance. Not too close, not too far, to allow them to safely make a connection with me. If I'm too far away, they will not reach me, I will not reach them. If I go too close, they'll get overwhelmed or I'll get overwhelmed or we get messed up and it collapses. So the whole, and this is generally for me in therapy, the whole game or dance is about the negotiation of the perfect proximity"* ***(P29/L527-531)*** *"I'm very up-close with people, I'm very touchy. That doesn't bother me. It starts to bother me when I sense that there is a complete disillusion of boundaries, and when I actually start feeling that this is going a bit mad and when I actually start to experience a full sense of madness which I'm not comfortable with. And that usually feels, happens when I feel I have lost all differentiation and I no longer know where is me, where is them"* ***(P30/L551-554)***
6. JOHN	*"...which gives you that certain amount of freedom to move, and once you got to that edge you stop yourself and you might be moved towards that edge and then to have just enough space before you go too far to rethink what's going on"* ***(P14/L93-95)*** *"Well, I realized that if I were to describe what was going on to certain members of the team, so that l would be down on the floor so to speak, that...I might be subject to some ridicule or embarrassment, or humiliation and being made to think that I shouldn't do that kind of thing"* ***(P18/L122-123)***
SUBTHEME 4.4: <u>BESTOWING MEANING</u>	
1. PAULA	*"Much more real. Less of a battle. I guess there is less of a battle for meaning really. I suppose is the difference there between trying to sort of either dissect or change meaning from a sort of CBT perspective. Working with beliefs or questioning delusions or whatever might be. To just being-with, hearing how they make sense, how the client makes sense of things. But often I think if someone's not ready to question or to change meaning they would have got it out in the first place. But again if they might be questioning meaning then this brings us more back to the relationship. So being present there and observing it. And this allows them to be present, I see that they feel not judged and more accepted and feel warmth in the relationship. Humanistic staff"* ***(P42/L197-201)*** *"...which enables them to deal with things in the here and now and to help them deal with some aspects of psychosis rather than to battle with it"* ***(P13/L61-62)*** *"And in the rest of my working life I am not religious as a person necessarily, or these huge amounts of customs and actually as a person I sort of resist to that but in my client work I accept it and see that it has value for people but it forces me really to question my own beliefs"* ***(P45/L214-216)***
2. BETH	*"And other things which did not make any sense to me, but if the relationship wasn't strong, I mean, I wouldn't be able to return, and make sense, and the same applied for him as well. All I'm trying to say is that I was very anxious but our strong relationship allowed meaning and survived the rupture"* ***(P26/L303-305)***

3. CARLA	*"But yes, with this patient the connection is strong, and it is important because, this is exactly why, I mean it is why we are able to understand his delusions, that why they are meaningful. It is exhausting though..."* ***(P34/L276-278)*** *"And one of the things that I kept reflecting about while I was talking to you, is how powerful it is for me as the therapist to be able to construct meaning with the client. And for me the only authentic way to do that is when the relationship is put on the spot, in, yes in the sense that we are connecting and disconnecting yes, but that it's part of the relationship. That safe space which is co-created is the cave where meaning is located"****(P36/L295-298)***
4. GEORGE	*"I cannot see how someone can't work with the person intersubjectively. It doesn't make sense to me but that's probably my experience of life, and the person that I am. It's not logical to me to any shape or form. That's where meaning is found, in that space"* ***(P14/L234-235)*** *"I asked him why it was important to have explosives in the session. And then he said I just wanted to simply see how you would react to this. And then I said I am mostly intrigued. And then I said something around, I wonder whether it's important to know you can blow the situation up if it became too much. He said yes, that would actually be quite helpful, but it is actually just water. So I said I get that. But the whole point I'm trying to make here it is about something, it's something about finding meaning in these things and understanding them intersubjectively. So for him the fantasy of a bottle that explodes was something that he brought in to test how far or close he can get to me, whether I could manage his madness, his anxiety and so on. And from there on he did that for 3 to 4 sessions and it was not an issue after, it stopped"* ***(P15/L247-252)*** *"So if you truly allow yourself to immerse yourself into the narrative of someone with an inner psychotic episode, what you come out with is the experience of how they are relating to the world, or how they are situated in the world, how free or not free they feel there, and it's always internally coherent"* ***(P5/L64-66)*** *"So every meaning that develops, every emotion that develops, develops from relationality or relatedness in that matter. Thereby we can only understand it and work with it in that domain"* ***(P14/211-212)***
5. JOHN	*"The case when one's responses parallel patient's but in this case was such a powerful feeling and that's why I put it together and it told me something about the patient. Suddenly it made me feel much more close to the patient. And sometimes you think you understand something about the patient and you are wrong. But here, this was something that lasted for weeks and months and opened the door to many other… (p). A much richer understanding of psychosis actually. Because the issue of shame and humiliation could explain the loss of other phenomena with this person"* ***(P19/L131-134)*** **"**So it's a question of just gradually making a psychological story that is useful to…rather than these strange bits of biology, and, totally explain it in biological terms. It's actually a psychological one. This makes sense in terms of his life and very…not just intellectually, way of understanding, but that the understanding was highly relevant to his real life issues. But also it makes sense through our relationship" **(P22/L187-189)**